H.R. 2600: THE HEALTH SECURITY ACT

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

OF THE

COMMITTEE ON EDUCATION AND LABOR HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

HEARINGS HELD IN WASHINGTON, DC, NOVEMBER 4, 9, AND 16, 1993

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H.R. 3600—"THE HEALTH SECURITY ACT: OVERVIEW OF THE PRESIDENT'S PROPOSAL: THE ROLE OF THE FEDERAL GOVERNMENT AND THE NATIONAL HEALTH BOARD"

THURSDAY, NOVEMBER 4, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to call, at 9:15 a.m., Room 2175, Rayburn House Office Building, Hon. Pat Williams, Chairman, presiding.

Members present: Representatives Williams, Payne, Klink, Green, Romero-Barcelo, Roukema, Gunderson, Fawell, Ballenger, and Hoekstra.

Also present: Representatives Reed and Goodling.

Staff present: Phyllis Borzi, council for employee benefits; Jon Weintraub, staff director; Gail Brown-Hubb, staff assistant; Russ Mueller; Ed Gilroy; and Patrick Beers.

Chairman WILLIAMS. Call this hearing of the Labor Management Subcommittee hearing to order.

This is a series of continuing hearings with regard to national health care reform. Last week, as you all know, the President sent to Congress the Health Security Act, his proposal for reforming our current health care system.

The President's proposal is, in my opinion at least, more detailed and more comprehensive and more ambitious than any other proposal before the Congress. It builds on the six goals that President Clinton outlined to the American people in his speech before a Joint Session last month. They are: Security, simplification, choice, price control, quality, and responsibility.

Because of the comprehensiveness and complexity of the proposal, however, it will, obviously, take some time for all of us to become fully conversant with the details. So to help speed up that process, we are fortunate to have with us today two individuals who have played important roles in the development process in the legislation. Dr. Judy Feder is the Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Dr. Feder is no stranger to the legislative process, having served as Executive Director of the Federal Commission.

Dr. Ken Thorpe is the Deputy Assistant Secretary for Health Policy at the Department of Health and Human Services. He is on

leave from the Department of Health Policy and Administration, School of Public Health, at the University of North Carolina at Chapel Hill.

Today, we have asked Dr. Feder to give us an overview of the structure of the administration's health security plan, and Dr. Thorpe will focus, I think, on the financing issues.

Dr. Feder, we will begin with you. We first thank both of you for being with us and we look forward to your testimony.

But before we do, I would like to see if my Ranking Member, Mrs. Roukema, has an opening statement, and out of courtesy to her, we have now turned on the speaker system.

Mrs. ROUKEMA. Oh, isn't that nice. And, hopefully, the lights will come on, too.

Thank you, Mr. Chairman. I am going to be very brief today. This is, what, the fourth or fifth in our hearings, and they have all been instructive; and as we go along, we can see, not only within this committee but in the context of the national press coverage of other committee hearings, we have learned that there is much that is known but also a lot that is not understood about the President's proposal.

And of course, increasingly, the issues which I have raised, whether they be issues of quality of care as well as the cost to the average person, the complexity of the program, but particularly the costs and the implications of how we control costs have been focused on in various committee hearings, and I am sure that will be the focus today. That is certainly my concern.

I do not believe that there is any contest or question about the goals for security and access in the President's plan, but highly controversial and increasingly controversial are questions that surround the implications for people such as those who are presently covered by good health programs. As I have been wont to say at times, and I think it bears repeating here, higher costs and lower access to care, less access to care, are not what my constituents had in mind when they were talking about health care reform.

But we shall go through these questions, and particularly I would like to focus today, and hopefully you will in your presentation, on the implications for the self-insured plans particularly. Because that is the precise scope of jurisdiction within this subcommittee.

Thank you very much. I appreciate your being here and we look forward to an informative discussion.

Chairman WILLIAMS. Do any other members wish to make an opening statement before we hear from our two witnesses?

If not, Ms. Feder, thanks for being with us.

STATEMENTS OF JUDITH FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND KENNETH THORPE, DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. FEDER. Thank you, Mr. Chairman, members of the subcommittee. It is a pleasure to be with you this morning. I think that the opening statements indicate that we are all committed to

achieving health security for our Nation's citizens, and what we want to do this morning is describe to you how the President's proposal will achieve that goal.

The President's proposal seeks to fix what is wrong with our health care system and preserve what is right. It seeks to strengthen all elements of the system so that those Americans who fall ill and those who want to preserve and improve their health can rely on a high-quality system that is affordable, portable, and permanent.

I am going to provide you an overview of the way in which that system works and then Dr. Thorpe will describe its financing.

First, let me emphasize that the President's plan proposes a private system. As you can see from the chart, under the President's plan, 76 percent of the financing for the nonwelfare, nonmedicare population will come from employers, employees, and other individuals making their contributions to the cost of coverage. The remaining 24 percent comes from government.

Again, Dr. Thorpe will describe how that works. Let me go on to the structure.

The President has laid out six principles that are at the core of our proposal and must be at the center of any health reform bill enacted by this Congress. They are security, simplicity, savings, choice, quality and responsibility. If any of these principles is dominant, it is security. Under our current system, no American has true security.

Most workers who lose their jobs, lose their insurance. People who change jobs often lose their insurance or almost certainly have to change their coverage. Families stricken by illness face the added burden of trying to make sure their coverage will not disappear. And conscientious businesses and individuals who attempt to buy insurance are often priced out of the market.

To solve this problem, the President's plan builds on the existing structure of health insurance but makes sure that all of our citizens are covered by a quality health plan they can afford. To achieve that, the plan asks States to create regional health alliances to help consumers and employers purchase the coverage they need. It asks employers to pay at least 80 percent of the average premium cost for a plan in their area, and it asks workers to pick up the remainder.

Every health plan will offer a comprehensive set of benefits to provide all Americans with the kind of care that our health professionals tell us is best: A package that has a strong emphasis on prevention; a package that covers inpatient and outpatient care; a package that offers specialty and primary care; and a package that includes mental health and substance abuse treatment coverage to help remove the stigma attached to these conditions.

We recognize that these new requirements may impose a challenge for some smaller companies, particularly those who do not currently provide coverage. So we provide significant discounts for employers that will hold the cost of coverage to no more than 3.5 percent of payroll for small low-wage firms, and 7.9 percent of payrolls for companies with more than 75 workers.

The majority of Americans should have no trouble paying the 20 percent individual share of whatever the individual's share is be-

yond what the employer contributes. They pay that much or more today. But for those with low incomes, people with incomes below 150 percent of poverty, for whom expenses exceed 3.9 percent of income, government provides additional protection.

Part-time or part-year or unemployed workers will owe some or all of the 80 percent share of the premium. They, too, get discounts, up to 250 percent of poverty, excluding, in calculating their income, $5,000 in wage income and unemployment compensation.

To further reduce the cost of coverage, the plan reforms the insurance market to eliminate underwriting practices that weed out the sick and cover only the healthy. No insurance company will be allowed to turn away anyone seeking insurance because of a preexisting medical condition. No plan will be able to follow that route. And by returning to the historic method of community rating, we will make sure that individuals and small businesses are protected from sharp premium increases.

Together, these changes will result in universal coverage of our population. In contrast, if we do nothing, the number of uninsured will grow from 37 million today to an estimated 55 million at the end of the decade: Nearly one in five Americans.

Another important element of security is predictability. Today, no person and no business owner can accurately predict what their insurance will cost them. Under the President's plan, all purchasers will know in advance what are their coverage costs and be able to plan accordingly.

In order to preserve that predictability as well as security, we must control the cost of health care. Through changes in the competitive market, our plan faces restraints on growth that will still allow spending to increase, but by an amount much closer to the rise in other consumer prices.

To ensure that these changes achieve the necessary savings, the plan creates a backstop system of enforceable premium caps to make sure no one will pay more for coverage than is appropriate.

The President's plan extends the concept of cost containment to all payers, public and private, but applying reasonable limits to the growth of medicare. We will curb its rate of growth, and we put those savings back into the medicare program through a new prescription drug benefit.

Without such coverage, many of our senior citizens are delaying the purchase of prescribed medications, independently changing their dosages to make prescriptions last longer, and even trading unused portions of prescriptions among neighbors.

The President's plan also ushers in a new era for our medicaid population. We will give them health security cards that will make them indistinguishable from any other American. They will enroll in a mainstream medical system that gives them the same benefits enjoyed by everybody else, plus the additional services traditionally provided through medicaid that enable people to use the health care system.

We all know that the current system is too confusing, too intimidating, and too expensive. We force our health professionals to waste their time filling out multiple forms and filing multiple claims. The President's plan will do away with the more than 1,500

often conflicting claim forms now in use and will substitute a single form that will be easy to understand and easy to complete.

Simplicity is another key to security. The system we propose will make it easy for consumers to gain access, get the care they need, and go on with their daily lives. It is structured from the consumer's point of view and is a clear and concise system that for most people will not be much different than the way they get health care now, except it will be they, not their employers, who exercise choice.

An important element of that structure will be the new Health Alliances. They will provide consumers and business owners real clout in the often daunting negotiations with insurers. Through the alliances, small firms and individuals will gain access to high quality coverage at the same price as big firms and under the same rules. Larger firms, with more than 5,000 employees, have an option to participate in the Health Alliances or to form their own alliances in which choices will also be guaranteed.

Alliances guarantee choice by making sure that a variety of plans are available, including a fee-for-service plan and a point-of-service option in every part of the country. And, once coverage is purchased, alliances become consumer protection watchdogs that help with any questions or problems that arise.

Once empowered, consumers and businesses must be ready to take responsibility for their coverage and their care. The President's plan offers Americans a great deal. In return, it asks something of everyone.

I will now turn to Dr. Thorpe to describe the financing of the system.

Chairman WILLIAMS. Thank you.

[The prepared statement of Ms. Feder follows:]

Judith Feder, Ph.D.

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

It is a pleasure to be here this morning to discuss the President's Health Security Plan. This is indeed a momentous occasion and the beginning of a process that I believe will lead to a better, stronger, and more secure health care system for all of the people we serve.

The President's proposal seeks to fix what is wrong with our health care system and preserve what is right. It seeks to strengthen all elements of the system so that those Americans who fall ill and those who seek to preserve and improve their health can rely on a high-quality system that is affordable, portable, and permanent.

We in the Administration have worked for many months to craft a proposal that addresses the serious deficiencies in our current system. We have consulted with hundreds of experts, including nearly all members of the Congress; we have gone directly to the people of this country to hear their complaints and their hopes.

The bottom line is that the quality of our current system is steadily eroding. You know all too well the fundamental problems:

o 37 million of our citizens have no health insurance, while another 25 million have inadequate coverage.

o Skyrocketing costs increasingly place coverage and care out of reach for many

Americans.

- Our system is weighted down with too much paperwork and too many bureaucrats.

- Many citizens watch helplessly as their health care choices evaporate, leaving them with no say in where they get their care.

- Our quality of care remains uneven, giving the majority of our citizens the best care in the world, but leaving some others with a level of care no better than Third World countries, and,

- Employers, governments at all levels, and individuals continue to exercise less responsibility for our national health care system and their personal health care.

The American health care system has lost sight of those who it is designed to serve -- the patients. We must change the system so that it is clearly understood and so that it serves all Americans when they need care.

We must get a handle on the cost of health care. We all know only too well the price we pay for uncontrolled health spending. While the overall budget of the Department of Health and Human Services has increased some 229 percent since 1980, almost all of that has been swallowed up by inflation in our health care programs. Medicare spending, for example, has risen 363 percent in the past 14 years. The Federal share of Medicaid spending has increased

even more dramatically -- 526 percent. As a result, health care programs have been the single largest contributor to our federal deficit and have systematically squeezed out resources that could be spent on other important priorities including education, job creation, infrastructure, and economic development.

Rising health costs and uneven health care coverage have also taken their toll on American businesses. Over the last decade the annual amount spent on health care by the average American family has more than doubled from $1,742 to $4,296. And that amount will double again by the year 2000 if nothing is done. Even in the last year, as the health care sector has attempted to slow its growth, two-thirds of American companies saw their health care costs rise; only 7 percent saw their costs fall. For many companies, health care costs are the single largest expense they incur; for many others, that expense is so great that benefits have been pared back or even eliminated.

In the five weeks since the President addressed the Congress, we have spent much of our time listening. Listening to the comments and advice of lawmakers here on Capitol Hill and legislators and governors in our state capitals. Listening to those who are in the health care trenches -- doctors, nurses, hospital administrators, and others. And listening to the people.

What we've heard has helped us to improve our plan. But let me make one thing clear, the one thing that has not changed is the core set of beliefs that have guided us from the start.

SIX PRINCIPLES

The President laid out the six principles that are at the core of our proposal and must be at the center of any health reform bill enacted by this Congress. (Chart 1) They are Security, Simplicity, Savings, Choice, Quality, and Responsibility. We've seen wide bipartisan agreement on these principles. That's good. Now it's time to begin making them a reality.

Today, I'd like to discuss some of these principles with you, starting with security.

SECURITY

It's not only the 37 million uninsured who lack health care security. They are only the most vivid evidence of this problem. Under our current system, no American has real peace of mind. Most workers who lose their jobs lose their insurance. People who change jobs often lose their insurance or have to change their coverage. Families stricken by illness face the added burden of trying to make sure their coverage won't disappear. And conscientious businesses and individuals who attempt to buy insurance are often turned away because the price is out of reach. At the same time, the lack of health care coverage in many low-wage jobs frequently traps young mothers in welfare.

To deal with this central concern, the President's plan builds on the existing structure of health insurance that has, for nearly 50 years, provided coverage to workers and their families.

(Chart 2) Under the President's plan, the largest portion of financing for health care premiums -- over three-quarters -- will come from employers and households through their

contributions to the cost of coverage. The remaining 24 percent will come from government.

(Chart 3) We have calculated that the federal share, including our contribution to premiums, public health investment, long term care, and deficit reduction will amount to $390 billion over the period of 1995 to the year 2000. We will produce that total in the following way:

- o $123 billion will come from savings achieved in the Medicare program. That will bring the annual rate of growth in that vital program more in line with growth in the private sector. About half of these savings can be achieved simply by continuing policies adopted by this Congress in the Omnibus Budget Reconciliation Act of 1993 and by reductions in payments to disproportionate share hospitals made possible by universal coverage.

- o Another $65 billion will be saved in the Medicaid program, by enrolling remaining Medicaid beneficiaries in private health plans with lower cost growth and then a similar reduction in the disproportionate share hospital payments.

- o We will produce another $40 billion in savings in other federal programs, including the government employees, military and veterans' health care.

- o Another $68 billion in federal revenue will come as a result of (1) slower growth in tax-exempt health spending that will produce higher wages and taxable

profits; (2) excluding health insurance from cafeteria plans; (3) other tax changes; (4) the corporate retiree assessment; and (5) reduction in debt service.

o And, finally, we gain another $89 billion by increasing the federal excise tax on cigarettes and the one percent assessment on corporate alliances.

How will these federal dollars be spent? The overwhelming majority of these funds will finance premium discounts for small employers, individuals, and early retirees. Another $66 billion will pay for the new Medicare prescription drug benefit; $65 billion will go for our long term care initiatives; $10 billion will pay for tax incentives and deductions for the self-employed allowed under the plan; and $31 billion will cover our investment in public health and some fairly minor start-up costs. That leaves another $58 billion in deficit reduction. I must point out to the Committee that we have deliberately built in a cushion of $44 billion to deal with behavioral effects that cannot be modeled.

UNIVERSAL COVERAGE

A key to security is the assurance that all of our citizens are covered by an affordable health plan. We achieve such coverage by asking states to create one or more regional Health Alliances to serve as the negotiators for consumers and employers. We ask our employers to pay at least 80 percent of the average weighted premium for a plan in each region with workers picking up the remainder. The vast majority of American firms already provide such benefits; in fact, many do even better.

(Chart 4) All health plans will be required to offer a comprehensive set of benefits to provide all Americans with the kind of care that our health professionals tell us is best. A package that has a strong emphasis on prevention. A package that covers inpatient and outpatient care. A package that offers specialty and primary care. And a package that improves on our mental health and substance abuse treatment coverage and helps remove the stigma attached to these conditions.

(Chart 5) We recognize that these new requirements may pose a temporary challenge for some companies, particularly those that currently do not offer coverage. Our plan provides significant discounts for employers that will hold the cost of coverage to no more than 3.5 percent of payroll for small low-wage firms -- defined as those companies with 75 or fewer workers with an average wage of $24,000 or less -- and 7.9 percent of payroll for all other companies.

Individuals will be eligible for discounts as well. For those required to pay the 20 percent share of a health plan premium, discounts will be available for those with income at or below 150 percent of the federal poverty line. Such individuals also will be protected by a limit of 3.9 percent of income on individual contributions. For the nonworking population that get no assistance from an employer with premium costs, discounts are available for those with non-wage income at or below 250 percent of poverty. And, finally, for retired workers between age 55 and 65, the federal government will eventually pay the full 80 percent employer share of the premium.

To further reduce the cost of coverage, we will reform the insurance market to eliminate unseemly underwriting practices that weed out the sick and cover only the healthy. We will end the practices of cherry-picking and cream-skimming. No insurance company will be allowed to turn away a person seeking insurance because of a pre-existing medical condition affecting that individual or a member of that family. Nor will insurers be allowed to continue pricing those who are sick or disabled out of the market. We propose returning to the historic method of community rating that served our country well and offered all Americans coverage at a reasonable cost.

(Chart 6) Together, these changes will result in virtually universal coverage of our population. In contrast, if we do nothing, the number of uninsured will grow from 37 million to an estimated 55 million at the end of the decade, or nearly one in five Americans.

During the last five weeks, we have gone over of the numbers in our plan, scrubbed them and rescrubbed them so that we can explain with confidence to you and to the American people how this plan will work. There are no rosy scenarios here, no magic asterisks. These are conservative numbers that will stand the test of public scrutiny.

A key feature of the President's plan is predictability. It will be easy for all Americans to determine the cost of their coverage and the scope of that coverage. Health plans will be required to offer four distinct classes of premiums for each policy: one covering single individuals; one covering couples; one covering single-parent families; and one covering two-parent families.

While the premiums charged by each Health Alliance will differ according to local community costs, we have determined the average national premium for each group in 1994 dollars. The national averages are as follows:

- o $1,932 for a single person.
- o $3,865 for a couple without children.
- o $3,893 for a single-parent family, and,
- o $4,360 for a two-parent family with children.

For those families and individuals who must pay the maximum 20 percent of these premiums, monthly costs will range from a low of $32 to a high of $73. As I said, these amounts will vary from state to state and community to community, but these national averages give us a good idea of how reform will change our current system for the better.

For employers, the new system will be predictable as well. According to our estimates for 1994, the average undiscounted cost to some employers will be as little as $1,546 for individuals and as much as $2,479 for two-parent families with children. With the premium discounts we offer, however, the cost to employers will be considerably lower.

Stable, predictable health insurance expenses will be of great value to business owners -- particularly small businesses -- who today cannot know with any reliability what their annual costs will be. Under today's system, one illness in one family can devastate a year of financial planning by a grocer or a hardware store owner. This must change -- and it will -- if we're going to have an economy in which small business can flourish.

SAVINGS

In order to ensure the kind of security I have just discussed, we must control the cost of health care.

In the current year, the United States will spend approximately 14 percent of its gross domestic product on health care. That is far greater than any other industrialized nation. In fact, our closest competitor in the health care arms race is Canada, which spends only 10 percent of its GDP on health care. If we do nothing about our costs, health care will rise to 19 percent of GDP at the end of the current decade.

Through changes in the competitive market, our plan places restraints on this growth that will still allow spending to increase, but by a much more reasonable amount -- one much closer to the rise in other consumer prices. To ensure that these changes achieve the necessary savings, we will create a backstop system of enforceable premium caps. That way, no company or individual will pay more for coverage than is appropriate.

We extend this concept of savings to all payers of health care -- public and private. By applying reasonable limits to the growth of Medicare, we can reduce the rate of that program's growth during this decade even while adding new coverage for prescription drugs.

By applying these limitations, we will expand the Medicare program to include an important new benefit covering the cost of prescription drugs. Numerous studies indicate that, without such coverage, many of our senior citizens are forgoing prescribed medications, independently changing their dosages to make prescriptions last longer, and even trading unused portions of prescriptions among neighbors. All of this is done in the name of saving money; all of it endangers the health and lives of our senior citizens. The end results of our efforts will be a stronger Medicare program that will continue to serve all of our senior citizens.

We also plan to completely transform our Medicaid program for acute care services. Medicaid beneficiaries have suffered too long with a system that offers, in many ways, second tier medical care. Uneven coverage and reimbursement rates have left too many of our needy citizens without coverage. And even those who are in the program are often turned away by health care professionals who refuse to accept Medicaid patients.

Under our plan, we place all of these individuals in a mainstream medical system: They will be enrolled in Health Alliances, which will provide them access to accountable health plans. Each Medicaid beneficiary will get the same health security card as all other Americans. They will receive the same comprehensive benefit package, plus additional services traditionally provided through Medicaid to allow access to the health care system. Non-cash recipients also

will gain access to these health plans with accompanying wrap-around benefits that will ensure that none of our neediest children will lose the services they now utilize.

SIMPLIFICATION

Another important element of a reformed health system is simplicity. We have all heard the complaints from the men and women who provide medical care. They tell us that the current system is too confusing, too intimidating, and too expensive. We are wasting time and money filling out forms, filing claims, and flailing at an unresponsive bureaucracy. Nurses and doctors often must take time away from patients to fulfill the demands of some faceless bureaucrat based 500 miles away.

Our new system (Chart 7) makes it easy for consumers to gain access, get the care and counseling they need, and go on with their daily lives. It is structured with the consumers' viewpoint in mind. And from that viewpoint, it is a clear and concise system.

(Chart 8) The Alliances will have important responsibilities but they will not be a new level of bureaucracy that gets in the way of business owners and consumers. Rather they will be a tool to cut through the bureaucracy of private insurance. The responsibilities of the Alliances are clearly specified in the legislation. Some of these are:

- Enrolling individuals in health plans and issuing Health Security cards.

- o Transferring premiums from employers and individuals to health plans.

- o Providing consumers with information about the quality and cost of health plans.

- o Working with health care professionals to develop fee schedules for fee-for-service plans, and

- o Serving as an ombudsman for employers and consumers.

The President's plan also assists health care professionals and institutions. We will do away with the more than 1,500 often conflicting claims forms now in use and provide a single form that will be easy to understand and easy to complete. And we will encourage greater use of electronic claims and speed the process of reimbursement throughout the system.

CHOICE

One of the prices we have paid for our current patchwork system has been the loss of involvement of consumers in the choice of their health plan and their medical providers.

Our proposal guarantees Americans a choice of health plans, including at least one fee-for-service plan. In many areas of the country, we expect there to be a great deal of choice. We realize, however, that in some parts of our country such wide-ranging choice may not be

quickly available. The President's plan calls for specific efforts to improve choice in rural areas of the country including the creation of new community health centers, a doubling of the size of the National Health Service Corps, provision of technical assistance to those who want to create new health plans, the training of additional mid-level practitioners, and designation of many rural hospitals and other health facilities as essential providers.

But we must remember that the greatest benefit we can provide to the rural parts of our country is universal coverage. Our most recent data indicate that 30 percent of our rural population is uninsured. This creates a tremendous drain on rural communities and the facilities that serve them. That will change.

The guarantee of choice goes beyond health plans. Americans are used to a system that allows them to select their health care professionals. This will be preserved. First, every Health Alliance will be required to offer at least one fee-for-service plan. Second, all plans will be required to offer a point-of-service option that will allow consumers to go outside the plan for services they desire. And, finally, all physicians will be allowed to join multiple health plans.

QUALITY

There is no question that any health care system must be based on high-quality medicine and must have built-in mechanisms to measure and protect that quality.

The President's plan calls for the creation of a National Quality Management Program designed to improve access, effectiveness, and appropriateness of care. Working with consumers and providers of care, we will develop national measures of quality performance; develop and improve consumer surveys; and recommend performance goals for the health plans.

In addition, the work now being done by the Agency for Health Care Policy and Research on practice parameters will continue and that information will be shared with all health plans and health care professionals as well as the general public.

RESPONSIBILITY

Finally, no system that we design can work without the participation of all involved. We offer Americans a great deal through our health care plan; in return, we ask something of everyone.

We ask employers to contribute to the cost of coverage for their employees. In return, we make sure that all companies play by the same rules and we give assistance to those who need it.

We ask employees to contribute to the cost of their coverage and to educate themselves about the choices available to them. In return, we provide lasting coverage that moves with them wherever they go.

We ask our caring health care professionals to provide high-quality care to all Americans

at a reasonable cost. In return, we eliminate the incidence of charity care, and allow health care professionals to spend their time with patients, not paperwork.

We ask our state and local governments to maintain their current efforts, particularly toward the poor and disabled. In return, we give states the maximum flexibility in designing their systems to meet their local needs.

CONCLUSION

In conclusion, Mr. Chairman, I believe we have come to an historic crossroads. One that allows us, as public servants, to leave behind us tangible evidence of our work and our caring; to fulfill one of the great unfinished items on our national agenda; and to create a sense of lasting security for all Americans on one of the most personal of issues, health care.

Working together, we can create a system of health care that is secure but not stagnant. One that is simple but not simplistic. One that saves resources instead of sapping them. One that offers choice instead of chance. One that guarantees quality for all, not for some. And one that asks for responsibility while eliminating risk.

We can do this. We should do this. And together I know we will do this.

Thank you.

Chairman WILLIAMS. Dr. Thorpe, please proceed.

Mr. THORPE. Mr. Chairman, members of the committee, I am pleased to be here with you today to discuss the financing of the President's Health Security Act.

The two points I would like to make in my brief statement is, first, the Health Security Act builds on the current private employer based health insurance system; and second, just to quickly reiterate that our estimates that we have spent substantial amounts of time refining and perfecting, I hope, are based on what we think are very conservative assumptions.

First, as Judy has already mentioned, just as today, the majority of Americans will have a portion of their health insurance premiums financed by their employers. The chart Judy shows shows a fully 59 percent of the premium dollars come from employers; 17 percent would come from households; government discounts for small business and low-income families would constitute the remaining 24 percent.

In response to consultations with the Congress and others, we have made several changes to the financing of the plan to guarantee fiscal responsibility and ensure the availability of necessary revenue before the addition of new benefits or programs.

First, the legislation extends the amount of time States have to come into the program. States may come in as early as 1996. They must all be in by December 31, 1997.

Second, the new long-term home and community-based care program is phased in over the 1996 to 2003 time period.

In addition, when we calculated the discount funding, we had added a contingency or cushion as a safeguard. We increased this contingency from 10 percent to 15 percent to create a stronger safeguard that sufficient funds will be available within the capped entitlement. We estimated the increased amount of discounts needed under several scenarios, including first if the economy were to suffer a significant downturn and if companies were to reduce their workforce to qualify for additional subsidies. The cushion proved more than adequate to withstand these scenarios.

Conservative assumptions. We made a number of conservative assumptions in developing our estimates. For example, we had two different estimates of the national average health plan premiums. We used the highest estimate to develop our estimates of what the discounts would be.

Second, we estimated discounts for small employers using a threshold of employers with less than 100 employees even though the policy only provides special protections to employers with 75 or fewer thereby overestimating the amount of discounts that flow to small employers.

Third, even though dual earner families with one worker in a corporate alliance and the other worker in a regional alliance have a choice of which alliance to join, we estimated all these families would choose the regional alliance. Corporate alliances are not eligible for discounts. They must self-finance discounts for low-income workers. Therefore, we maximized the amount of discounts available to these dual earner families.

With respect to our review process, we had a very complete, timely, and detailed internal review process that included a num-

ber of departments and agencies. We had teams of actuaries and economists from the Executive Office of the President: The National Economic Council, the CEA, OMB; within HHS from the Health Care Financing Administration, the Agency for Health Care Policy and Research, our office within Planning and Evaluation. The review process included the Treasury Department, the Labor Department as well as think tanks and consulting firms.

External review. As you know, the normal course of business in the Federal Government is to develop budget estimates internally. However, health reform is too important to proceed on a business-as-usual basis. Therefore, we used an unprecedented process of external review. We organized an outside group of actuaries and health economists from nationally recognized consulting and accounting firms and Fortune 500 companies. During our model building and estimation process, we solicited their analysis, suggestions and in many cases incorporated them into our results.

In addition, I want to note that while we had several estimates of the costs of the program completed within both the Treasury Department and HHS, we also had an outside, private, not-for-profit organization, the Urban Institute, develop estimates all through the process as well, and in many cases we have made sure that the estimates that we have developed internally coincide with what the estimates have been from this outside research group.

Let me quickly go through with that in mind about the process of how we developed our estimates of an overview of the numbers.

If you look at the chart that we have up in front of you, which I hope your eyesight is better than mine; if not, I will be able to read the numbers off to you. Let me just discuss the highlights of the financing plan during the 1995 to 2000 time period.

On the left side of chart, you will see it says sources of funds. On the right-hand side of the chart is uses of funds. I will start with the sources of funds.

First, with respect to medicare, the legislation has a set of very detailed proposals that will generate $123 billion in savings. Let me just quickly characterize where the savings come from.

First, 23 percent of the proposals are extensions of expiring authorities such as the medicare secondary payer provisions.

Second, 34 percent of the proposals are funds currently paid to providers who serve a disproportionate number of low-income persons. Universal coverage renders such spending duplicative.

The remainder help bring down the growth in the medicare program to twice the level of inflation rather than the current rate of growth, which is well over three times the rate of inflation.

So the medicare program, the rate of increase in health spending during the time period without any of the proposals, currently is about 10.8 percent. After the $124 billion in savings package, that rate of growth would be 7.4 percent, and if you include the prescription drug program and the medicare spending, the rate of growth would be 8.4 percent. So what we are talking about is simply a 2½-percentage-point reduction in the rate of growth in the medicare program.

Medicaid, which is the second line down: $65 billion. These savings come primarily from medicaid cash assistance recipients now being covered through the alliance with an associated lower growth

in outyear spending as well as reductions in disproportionate share payments made to hospitals.

The third line down is a tobacco tax and a corporate assessment. The tobacco tax is an excise tax on tobacco products, which would raise $65 billion during this time period. This is an increase in the cigarette tax to 75 cents per pack, which would raise the Federal tax from 24 cents to 99 cents per pack. The corporate assessment would raise $24 billion and the corporate assessment is an assessment of 1 percent of payroll for firms outside the regional alliances.

The next line down is other Federal savings: Federal programs such as the veterans, defense, the Federal health plan, the Public Health Service will achieve savings from shifting to alliance coverage as well as lowering the rate of growth in health care spending.

Chairman WILLIAMS. Let me interrupt and ask over what time period do you anticipate these savings in these revenue sources.

Mr. THORPE. Primarily 1996 to the year 2000. There are some dollars on the uses side that come in 1995. Those are primarily start-up costs to get the system up and running but most of what I am talking about is 1996 through the year 2000.

The next line down, which is other revenue effects, these are, we believe, scorable savings that the plan will engender. They include revenue gains from the combination of the employer mandate, discounts, and cost containment; removing health insurance from cafeteria benefit plans; other tax changes, largely for antiabuse rules and increased penalties for noncompliance; and employer assessments for the early retiree policy.

There is another line down there of debt service, $4 billion which constitutes a reduction in debt service payments.

On the uses side, where the money goes, I will start with public health initiatives and administration. This is broken into two pieces. We do have new public health spending in the plan, which is about $15 billion. The remainder represents administrative costs as well and start-up costs.

The next line, long-term care initiatives, this includes new spending for the home and community-based care program, which is the bulk of this. It is about $57 billion as well as liberalized eligibility under medicaid and tax incentives towards the purchase of long-term care insurance.

The medicare drug benefits, which is $65 billion, is an expansion of the medicare benefit package to cover outpatient prescription drugs.

Following, next is the self-employed tax deduction which would cost $10 billion. This represents a cost of extending tax deductibility to 100 percent of premium payments for the comprehensive benefit package to the self-employed.

Finally, if you look at the final three categories, the first two have to do with premium discounts. These represent the costs of discounts for employers and individuals, low-wage individuals. Just to give you a sense of the breakdown of this, employers would receive 29 percent of the discounts; families, 58 percent; and the remaining, which I have down there under cushion, represents 13 percent of the total.

You can see that the cushion, that is the 15 percent contingency we built into our estimates, represents about $44 billion of additional contingencies that we put in there during the 1996 through year 2000 period.

Finally, deficit reduction. During the time period that we have looked at, we projected that the deficit, that there be $58 billion in deficit reduction.

With respect to the year by year, the impact on the deficit really starts to have a very significant effect during the 1999 and 2000 time period. For example, in the year 2000 alone, we are projecting a reduction in the deficit of $35.8 billion.

This is a very quick overview. I would look forward to working with the committee during the next several months as we develop the legislation, and I believe both myself and Dr. Feder would be pleased to answer any questions you may have.

Chairman WILLIAMS. Thank you. Thanks to both of you.

Dr. Thorpe, what would be the cost of administration—what is the percentage that you would estimate would be assumed by administration?

Mr. THORPE. I am just looking up. I believe it is about $9 billion over the time period.

Chairman WILLIAMS. Nineteen ninety five through the turn of the century?

Mr. THORPE. Right. Again, there is a little bit of start-up cost in 1995, but most of it is 1996 through the year 2000, that is correct.

Chairman WILLIAMS. As you know, there has been significant controversy about the 8.4 percent rate that you assume for growth, for growth in medicare and, thus, savings. I personally do not think the criticism of that growth rate assumption or the doubt expressed about it is directed at this particular plan or at the President or the task force or even at the review, but, rather, we know historically that the insurance industry, the medical community and the government assumptions have been off by substantial amounts in our projections.

What can you tell us to help us have greater respect for that 8.4 percent figure?

Mr. THORPE. Well, I think in general, with respect to the estimates that we have made, I would make just two quick points:

First, that the bulk of our estimates really focus on the discounts, in terms of the Federal expense of this. What I would say about that is that we have, I think, a tremendous amount of information that underlie the estimates that we have made which primarily are estimates of what it costs to insure somebody who is currently uninsured.

This is an area, at least in the academic world, where we have, I think, two decades of very solid empirical research which documents the expense of taking somebody who is uninsured and providing them insurance. So on that point, I think that the outside world, when they look at these numbers, will largely agree with the estimates of what it costs to take somebody who is uninsured and provide them insurance.

With respect to medicare, the estimated savings—of course, the CBO will look through this and come up and make their own assessments. These are estimates from our Office of the Actuary—

they are estimated savings of programs that they have looked at before. They primarily, in many cases, represent changes in the way that we pay hospitals and physicians, and on the outpatient side as well.

And I think that their database and their estimates of the medicare savings, as well as I believe the way that CBO will look at this as well, that there will be a large degree of agreement between CBO and HCFA on the aggregate package.

So I think with respect to their costing of these savings, that we feel quite confident that the savings that they have priced out for our programmatic proposals are going to be quite accurate.

Chairman WILLIAMS. Dr. Feder, yesterday you may have seen the New York Times editorial, which has a headline which says *A Misleading Health Estimate.* The editorial begins with these words, "The administration's estimate that 40 percent of insured families would pay higher premiums under its health care bill jarred everyone on Capitol Hill last week."

The editorial then goes on to explain that the 40 percent increased cost is, in fact, misleading; that it would not be 40 percent. The editorial then ends with this paragraph, "The important point is not that the administration knows for sure who would win or lose under its reform. It doesn't. But the administration can tighten its performance and needs to do so if it expects to prevail in the long struggle for health care reform."

It ends by saying that the effort can start this week because important administration witnesses will be on Capitol Hill. So would you like to start the tightening up process by telling us whether or not 40 percent of families in this country are going to pay higher premiums?

Ms. FEDER. We would be delighted, Mr. Chairman.

First of all, the Times very helpfully clarified there was misinterpretation of the 40 percent in that that included about 25 percent of the population who would pay more but get more improvements in their benefits; and another 15 percent would pay somewhat more because they are being part of a community rating process in which we are all sharing the responsibilities and the risks associated with insurance coverage.

But as part of tightening up our performance, we have reexamined the impact on the population, looking not only at insurance premiums, but at what people pay out-of-pocket for their health care. And I think that Ken can speak to that issue and more clearly state what the implications are of reform.

Mr. THORPE. The figures that you have cited simply were looking at what the currently insured population would pay for premiums today versus under reform. In order to provide a more complete picture of what people actually spend, it is appropriate to add in what they pay out-of-pocket as well as for premiums.

Chairman WILLIAMS. Deductibles.

Mr. THORPE. Deductibles and copays to be included. That gives you the complete picture of what people pay today for insurance versus what people would pay under the President's plan for insurance.

When you look at the figures, which include premiums plus out-of-pocket payments, nearly 70 percent of Americans would spend

the same or less under the President's plan; and of that 70 percent, on average, individuals would save $737 per year.

So I think, just to clarify exactly what this is, this is in 1994 dollars. This assumes, really, that the program is up and running immediately and that we have not built in any savings yet from the President's plan. So you can imagine that by the year 2000 or 1998, when the plan is fully implemented, that the number of individuals that will spend the same or less does increase, as does the average family savings.

So this is immediate implementation. It does not assume any savings. When you include out-of-pocket as well as premiums, nearly 70 percent will spend the same or less, and the average savings would be $737 per year.

Chairman WILLIAMS. Thank you. Mrs. Roukema?

Mrs. ROUKEMA. Mr. Chairman, Mr. Ballenger has another meeting, and so I am going to defer to him for the first question.

Chairman WILLIAMS. The gentleman is recognized.

Mr. BALLENGER. I thank you, Madam Chairwoman. Assistant Chairman, excuse me.

One question. As a businessman myself, and recognizing in the past for many employers ERISA, especially ERISA preemption, has worked to help self-insured employers, which is my company, to keep their health plan costs affordable. This is particularly true in that ERISA remedies for contested claims have been found to preclude punitive and compensatory damages.

And recognizing that lawyers wrote this bill, it scares me. But if ERISA had allowed the golden rings for trial lawyers, we would have had the same claims litigation go through the roof in the same way malpractice costs have led to unsupportable costs for defensive medicine. Somewhere along the line everybody says that is one of the biggest savings we could create. But I am not sure.

It appears that in your 1,342 page draft it does not include punitive and compensatory damage with respect to claims disputes in either corporate alliances or regional alliances. And my question is whether you agree these types of damages would be detrimental to containing costs, and under what circumstances, if any, such damages are found in the Clinton plan?

Ms. FEDER. Congressman, we have retained current law for those corporations who continue to self-insure. And for those who are in the regional alliance, there is access to the judicial system.

Mr. BALLENGER. But ERISA preemption is almost included in this bill, is it not?

Ms. FEDER. There are many changes in ERISA, essentially. But ERISA continues for—the ERISA preemption continues for those firms who take advantage of the opportunity to maintain their own alliances; those firms who have more than 5,000 or more employees nationally.

Mr. BALLENGER. Am I mistaken in saying that as far as Health Alliances are concerned that the claimants can go to State courts and get this?

Ms. FEDER. As far as regional alliances are concerned, they can. The Health Alliances and——

Mr. BALLENGER. Isn't that a big can of worms to throw out there?

Ms. FEDER. Our concern here is to provide individuals protections, appropriate protections, whether they be in the Health Alliances, the pools, or in the corporate alliances. We have administrative remedies as well as the judicial system.

Mr. BALLENGER. But, again, you are using the courts to take care of this punitive and compensatory damages, which actually is one of the major factors in the cost, exploding cost of medicine today.

Ms. FEDER. As I indicated, Mr. Ballenger, I believe we are retaining current law.

Mr. BALLENGER. Current law has allowed medicine to explode the way it has?

Ms. FEDER. Well, you alluded to the issue of malpractice here, and we have made a number of changes with respect to malpractice that include and emphasize an attempt to stay out of the court system, and I think that applies to our administrative remedies throughout; that in terms of malpractice, we have created a requirement that plans must have a grievance procedure; that there must be approval, a certificate of merit for going to, before going to court.

We believe that alternative dispute resolution mechanisms will greatly reduce going to court. We have put limits on lawyers' fees and we believe that this combination of changes, along with the development of a quality improvement program, really is the best way to assure appropriate——

Mr. BALLENGER. The limits you put on legal fees are the same limits they have right now; is that not right?

Ms. FEDER. We have established a limit. States can exceed, I believe it is a third.

Mr. BALLENGER. Which is about the tops right now. So the lawyers are still going to get rich off of this situation.

Ms. FEDER. Well, the States can do more in that regard if they wish, but we believe that establishing the limit is the appropriate way to go.

Mr. BALLENGER. One more question. All we are doing is playing with your, Mr. Thorpe, with your statistical analysis here. All we talk about is Federal funds. What percentage of the total expenditures are Federal funds? There are no premiums listed there. What is the total cost of the whole program?

Mr. THORPE. If you go to the pie chart over there.

Mr. BALLENGER. What is 59 percent of what?

Mr. THORPE. If you think about this in terms of premiums, which includes both the corporate alliance premiums and the regional alliance premiums, there is $321 billion of premiums in 1994 dollars.

Mr. BALLENGER. But you have $390 billion in Federal funds. How does that match up?

Mr. THORPE. That is a five-year number.

Mr. BALLENGER. Okay. And the other is a one-year number?

Mr. THORPE. That is correct, it is a one-year number.

Mr. BALLENGER. Okay. Thank you, Madam Chairwoman. I hope I have messed it up nicely.

Chairman WILLIAMS. Mr. Reed.

Mr. REED. Thank you, Mr. Chairman. This is a question for either Dr. Feder or Dr. Thorpe.

Part of the financing is going to come through reductions in medicare reimbursements and the elimination of the medicaid program, or effectively rolling it in. Right now those health providers who depend substantially on medicare revenues will also be required to provide additional services. Particularly for small operations, like small health care centers, who provide health care for their employees, have your calculations factored in the increased or added labor cost of providing health care for those medical facilities that do not do it now?

Do I make myself clear?

Mr. THORPE. The analysis that you have seen here is looking at the aggregate impacts. We have looked at the change in spending for business, and we do have that broken down in different ways, by industry and by firm size, as well as we have it broken down for households by income and composition of the household. I would have to look at our industry breaks to see how we find we could make some of those estimates.

Mr. REED. More specific, and perhaps I can make my question clearer, on one hand we have proposed to reduce substantially medicare expenditures going out four or five years. On the other hand, we have many medical enterprises that depend upon those expenditures as their sole or practical sole source of revenue. And part of the formula of medicare is the labor component, and we are going to unilaterally raise the price of labor to these people.

I am wondering how on one hand we can compress medicare payments and on the other hand we are going to have to follow through with the spirit at least of the formula's increased payments to providers to cover their own now mandated medical expenditure.

Ms. FEDER. I hear your concerns, Congressman, and I think we will have to look more closely at our data to address the specific concern you are raising with respect to the labor component.

But I think it is also important to note that what will change in the marketplace for these providers, in addition to the changes you mentioned, many of those providers who are heavily medicare dependent are, in part, in that circumstance because a lot of their other population has no insurance protection at all or limited insurance protection. As we move to universal coverage, what we are doing is greatly enhancing the capacity of the people in that area to use providers and to pay for their care, eliminating uncompensated care, and compensating providers for their service.

So we need to have that in the equation as well, but we will look into this matter for you.

Mr. REED. Another question, and again I don't know which or both might field it.

Ms. FEDER. We like to share. It is okay.

Mr. REED. That is a good spirit, please keep it up.

In the construction of the health care alliances, there is, at least initially, the thought that they would be contained within States; they would not spill over.

An initiative came up in my State, particularly because it is a rather small State, and in fact we have medical facilities that sit right on the border with Connecticut and western Rhode Island. Even Providence, which is the center really, the medical center of

southeastern New England, is frequently visited from people living in adjacent Massachusetts. There is a concern that the State alliances will rigorously state that there will be incentives to keep people in States and, contrary, disincentives to prevent people from coming across the border as they do now.

In Rhode Island, and many other places, the irony is that people living in Seekonk, Massachusetts are closer to Rhode Island Hospital than someone living where I live. I am wondering if you have thought through this in terms of the availability in the capitated system to reach across State lines and bring people into other facilities?

Ms. FEDER. Absolutely, Congressman, and I think there are two issues here. What is I think most important to us as consumers is that the health plan that we are in enable us to use the providers that we choose that are most convenient to us. And, consequently, health plans are highly likely to cross boundaries as they do today, in order to best serve consumers.

Consumers also, through the fee-for-service plan or the point-of-service option, can go to any provider of their choice, independent of State boundaries. So we have given extensive attention to that provision.

With respect to alliances, when we rely on a State system, we do run into some boundary issues. We have included an explicit provision that allows, or some might argue encourages, cooperation across States in their alliance formation. So we need to look at both those issues. But I think in terms of consumer choice and providers being able to count on consumer choice, that we have accounted for that issue.

Mr. REED. I just want to comment, one of the concerns I sense out there is that in a capitated system there is going to be a real strong sense of gathering up as many people as you can under these systems. And if you have, for example, a health plan that is incorporated substantially based in a certain State and working closely with that State and with that health alliance, there will be, if not a formal, an informal set of rules that will encourage staying within the borders.

I think this is an issue that cannot be settled today, but I think it is an issue we have to be acutely aware of as we go forward.

Ms. FEDER. We share your concern, particularly from the perspective of the consumer, because we believe that ensuring consumer choice and access to a full array of providers is a critical element of reform. And so if we need to address that further, we would be happy to look at that with you.

Mr. REED. Thank you. Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you. Mrs. Roukema, let's go back to you.

Mrs. ROUKEMA. Thank you, Mr. Chairman. I had not really intended to get into this choice question and who means what by choice, but I will simply make this statement and I am not going to give you time to argue it because I have another question I want to get to.

With your chart and the follow-up to my colleague's question on choice, I think that the whole debate is a question of definition and of what choice you are talking about. I believe that my constituents

are looking for choice under the same rules that they know now, that is, choice of doctor, choice of hospital. I don't see that in your plan, unless, unless they pay an extra premium for the privilege.

Now, you may have choices between plans, and I think you have made that case, but I think those that are concerned about choice are concerned about choice of doctors and hospitals on a specific basis, whether you call it fee-for-service or whatever, and I think that is the argument.

I know this is a very, very intense issue in my district, and I suspect it is an intense issue every place where they presently have good health coverage through their employer. So I just want to make that point and say that that is a big stumbling block in our area.

I will be happy to go over the numbers, Dr. Thorpe, that you have outlined here. We don't have the time. But I have to suggest that, again, even though they have been modified somewhat, and Senator Moynihan has been somewhat mollified—I am not quite sure he has been completely mollified; but somewhat mollified—I still find that the sources of Federal funds on the savings side are of a magnitude that lack credibility, and particularly in the medicare savings. I just cannot accept that.

For example, I don't know of anyone being commissioned by your task force on the outside who can quantify or evaluate those numbers. We do not know what went into them. For example, I have never heard anyone explain the assumptions about the size of the medicare population, and we know how much that is growing as a percentage of our national population. So I have to say it still sounds strangely like a free lunch to me. I have to say that, and we will go over that at another time.

But my specific question is concerning the potential for leading to price controls. Under the President's plan, it is my understanding that the States will be responsible to see that the average premiums charged under the regional alliances would be held to the annual limit set by the National Health Board. Under the plan, would the States be given the flexibility to meet their responsibilities by establishing hospital and doctor rates or using other price controls to achieve the desired goal?

This subject has been raised on a number of occasions. In the alternative, to keep premiums from exceeding the annual limit, could States eliminate insurers and corporate alliances, fix hospital budgets or institute other means of reducing the utilization of medical services? Because that is what we are really talking about here. Either price controls—no, not either/or, price controls and limited utilization of medical services, which is another phrase for rationing.

I will leave that up to you, please. Would you respond?

Mr. THORPE. Just two seconds on the medicare. Just remember that, again, this is a number that is a five-year number, through the year 2000. If you put it in the context of the baseline medicare spending over that time period, as I mentioned, it is simply about a 2½ to 3 percentage point reduction off the baseline. So even after——

Mrs. ROUKEMA. I hear what you said but I don't know what goes into that.

Mr. THORPE. Sure. And CBO will certainly go through it in detail and make their own assessments of what the programmatic savings are. So CBO is, I am sure, looking at them as we speak.

Mrs. ROUKEMA. We will be sure to look over that, but I was thinking of something more independent; a more independent auditing firm.

Going back now to this question of price controls and the potential for rationing here and the relationship between the National Health Board and the local alliances.

Ms. FEDER. Okay. I think in a number of your questions that what we are doing in the system is changing the health care delivery system, and it is in that way that we are achieving cost control. In doing that, though, we are not eliminating choice.

Essentially, alliances take all plans. No limit on the number of fee-for-service plans. Everyone is guaranteed a fee-for-service option. And then those plans, as well in that choice, are held to their premium bids, the ones they bid themselves, and are held accountable for that bid. And in that regard, all plans, whether they be fee-for-service or organized delivery systems, will likely be ultimately of lower cost in the future, lower premiums, than they are today.

With respect specifically to State activities to control cost, this is a State flexible system. We have not given States new authorities in that regard. States have the authority that they have today in dealing with their health care systems.

Mrs. ROUKEMA. You left out the role of the National Health Board here. But you are essentially saying that the cap—I don't know how much latitude these different alliances are going to have, but they will all be within a certain budget cap and, therefore, it seems to me to be a distinction without a difference.

Ms. FEDER. Let me continue. I was focusing on your question where you asked about State tools. I thought that was the concern.

In terms of caps, we see that essentially as a backstop in order to guarantee affordable costs in a changed marketplace. When I talk about the changed marketplace, we are relying upon a system in which plans offering the guaranteed benefit package, again a full array of plans, or bidding to offer that guaranteed benefit package. And it is their bids that really are likely to influence the cost of service. They will, as we discussed earlier, be competing for a large population who will have reason to choose cost-effective plans, and we expect those bids to determine prices.

We have then—the national board does establish a backstop limit on the weighted average premium, specific to each area and reflecting the cost experience in that area.

Mrs. ROUKEMA. Well, my concern is that we can always come within certain cost limitations if we are willing to limit the scope of care.

Ms. FEDER. And what we are doing is essentially focusing on changes in the efficiency of delivery of care to achieve those objectives, and we can go into at greater length, if you wish, what those efficiencies are going to be.

Mrs. ROUKEMA. That is where the skepticism arises particularly with people like Senator Moynihan and myself that efficiency is one thing, we don't doubt we need more efficiency in the health

care system, but the magnitude of the savings that are projected simply stretch the imagination.

Ms. FEDER. Well, Mrs. Roukema, I understand your concern, because it really is critical that we provide quality care and the scope of services we intend. And as we have over the last several months worked with providers and consumers around the country, we have found case after case in which plans feel that they are able to deliver appropriate and necessary care more efficiently in a changed system, and that is what we are building on.

Mrs. ROUKEMA. Thank you. We will be glad to go over your testimony in detail. Thank you very much.

Chairman WILLIAMS. Mr. Klink, questions for these witnesses?

Mr. KLINK. Yes, and I would like to follow up, if I could, and, first of all, thank Dr. Feder, who was kind enough to come into my office and try to help me figure all this out. It is still very confusing and I want to follow up on what Mrs. Roukema was just asking.

In plain language, when you talk about that kind of medicare and medicaid savings, on top of the savings that we already had in the President's budget package, how do I go back to a hospital in Beaver Falls or New Castle or one of the major medical centers in Pittsburgh and say to them, you know, we are going to whack you again on medicare and medicaid, but you don't have to worry about—it is not really going to hurt you. Where are we able to prove that this kind of savings is not going to cause some pain on the deliverer?

Mr. THORPE. I will try to help you out in making three points. First is that for that hospital, if you look at the administrative simplification laid out in the President's plan for hospitals, single claim form, which will greatly simplify their life.

Mr. KLINK. And will cause the layoff of a lot of people I imagine who fill out claim forms.

Mr. THORPE. There will clearly be a change in the composition of labor within the health industry, no doubt.

Mr. KLINK. Thank you.

Mr. THORPE. That, second, if you look at the credit and collection departments that spend most their time tracking down people who are uninsured, who have bad debts, that that part of their life is going to be dramatically simplified. So I will say on the cost side, the cost of doing business for hospitals in this country, is going to fall.

The second point I would make for your hospitals would be that the individuals who are ill and admitted for care will all come in with health insurance; that they will all be paying at rates that private plans have bargained and negotiated with hospitals, which is a dramatic departure from what those hospitals have today. They are dealing with medicaid clients, they are dealing with uninsured populations, and indigents, and providing a tremendous amount of uncompensated care. That will no longer be the case either.

The third thing that I would say is that even though, again, the medicare savings, when you sum them up over a five-year period, and the numbers do look large when you aggregate them that way, as I mentioned, that even with what we did in the budget and this,

that the growth in medicare spending is still over 8 percent after the program is put in place.

So those would be the three points I would make to your hospital administrator.

Mr. KLINK. One other question, and you brought it up again, and none of the hearings I have been to thus far, in any of my committees, have I ever thought of asking this question. And if it has been answered, I apologize. I just don't know.

Where is the enforcement in all this? We keep saying everyone will have the insurance. Where does the enforcement come from in all of this to make sure that, in fact, everybody provides the insurance, everybody pays what they have to pay, buys what they have to buy?

Ms. FEDER. Essentially, there are national guarantees in the program with the first round of enforcements coming in different places.

The insurance reforms you are talking about and the collection, the first line of responsibility in the original alliance is with the alliances and then with the States. They are backed by the State for collection purposes. For collection purposes, they are backed in terms of the employer's share. They are then backed by the Department of Labor on the individual's share. They are backed by the enforcement of the Department of Health and Human Services.

So there is an enforcement mechanism to ensure that the moneys are collected. There is an overall enforcement of compliance, and we expect States to put systems into effect that do achieve the national guarantees, because it is their citizens they are serving.

But there is a requirement that States submit plans to the national board. Those plans must be approved and then compliance is monitored.

Mr. KLINK. Is the Federal Government going to set the penalty or will the States set the penalty for those out of compliance?

Ms. FEDER. Out of compliance—the States. There is—essentially, we are talking about a State being out of compliance. It is in those unfortunate and unlikely circumstances that the Federal Government would intercede and there are penalties involving a withholding of some Federal health funds or in extreme circumstances the alliance, the whole system would be created by the Federal Government until the State was ready to take it back.

Mr. KLINK. And getting back to Mrs. Roukema's question before, I wish I had the memorandum here, but the CBO issued a memorandum that suggested that the premium caps imposed on insurers might have the effect of reducing services and eroding the quality and really impacting medical technology.

Do you have a reaction to that memorandum and the fact that we in fact may be impeding all of the things that made our—the good part of our medical system; the technology that we have had, and the fact we have had this available?

Ms. FEDER. I would hope to alleviate your concerns about that memorandum. Because the CBO memorandum was looking at imposing premium caps in our current system, which would indeed potentially be disastrous. What we need, when we put the kind of backstop premium caps we have in a comprehensive system, with new rules for insurers, critical in that regard, we have essentially

taken all the precautionary measures that CBO recommended in that memorandum and more.

Mr. KLINK. If I could ask one quick question here.

We are going to see, of course, a transition from institutional care to home-based care. How are we going to train these people? Where are the people going to be trained for these new health fields that will be created by this change?

Ms. FEDER. You are right. We need training not only long-term care but primary care in general. Consequently, we have included in the reform proposal a number of initiatives for training of all kinds.

Incidentally, or not so incidentally, including retraining of workers that you were concerned about in your hospitals to ensure a growing supply of properly trained, well-qualified health professionals of all kinds. So those are specific initiatives included in the reform proposal.

Mr. KLINK. Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you. Mr. Hoekstra?

Mr. HOEKSTRA. Thank you and welcome to the hearing this morning and I appreciate your testimony.

Can you explain to me how we got to a standard benefit package of a typical Fortune 500 company?

Ms. FEDER. As we looked at establishing a guaranteed benefit package, which we think is really critical—people need to know what they are getting—we essentially looked at what people have today. And people who are well insured today count on the coverage for the hospital services, physician services, prescription drugs, the kinds of services that you need when you get sick. And if we are going to provide security, it is that scope of benefits that becomes essential.

Where we have somewhat expanded is in the area of prevention and that is an area we think that preventive services need to be part of the package in order to make certain that we promote health, which is really our ultimate goal.

Mr. HOEKSTRA. Did you benchmark your program against a standard Fortune 500 company? Somewhere there must be a survey of these. Are there 10 Fortune 500 companies that, through wellness programs, through individual responsibility, are leading the fight in terms of cost containment? Could you tell me who those five to 10 companies might be; what the characteristics of their plans would be; and how the Health Security Act would benchmark against those programs?

Mr. THORPE. Let me give you a little bit of a sense of some of the analysis we have done with respect to looking at our benefit package relative to what companies and individuals currently have.

As you know, the Department of Labor collects information from companies today through their summary plan descriptions; very detailed information on the scope of benefits as well as the copays and deductibles associated with those benefits. We have that information on an automated rate file, if you will, so that we can compare in tremendous detail benefit-by-benefit, copay-by-copay, our benefit package with the benefit packages that were reported to the Department of Labor. So that is one set of analyses we have done.

And we have found that the benefits package that the President has put forth is better than half of the benefit packages that are in that data set, which is, to my knowledge, the most comprehensive survey of health benefits in the country.

Second, we have gone ahead and have worked with several companies looking at some of their plan designs, some of the bigger companies in this area as well, comparing our benefit package to theirs. As Dr. Feder has mentioned, ours is somewhat different than the typical benefit package in, we think, two respects.

First, the range of preventive services that we put forth with no cost sharing is quite unusual. And what we have proposed here is really to, I think, rethink the nature of insurance packages, moving it away from what it has traditionally been in terms of focusing on acute care, institutional care, care that is provided after you become ill, to a benefit package that really focuses on prevention and trying to keep individuals healthy so that they do not need the care.

So that is new and that is something that most companies that we have looked at do not have the range of preventive benefits in their package, and certainly do not have it with no cost sharing. But those are the types of analyses.

We have done several studies with individual corporations looking at plan design with respect to the mental health benefit, the preventive package and so on, and we have done this much more comprehensively comparing a range of corporations that have filed their very detailed summary plan descriptions with the Labor Department.

Mr. HOEKSTRA. I am still very skeptical of the Department of Labor information and documents. Better than average is not good enough. I guess what I am saying is can you tell me who are the best 10 out of the Fortune 500, or even a survey of medium sized companies?

I have a company in my district that claims that they have reduced their premiums 30 to 40 percent below a Fortune 500 company, such as the company that I worked for, through aggressive wellness programs including putting more accountability and responsibility on employees.

Can you give me a list of who those companies are, the characteristics of why their programs have reduced costs, and how this program benchmarks against that? What features you have included, which features that you have deleted?

I have a hard time believing that perhaps as good as the health security plan is, that this is the best plan in the country today and that there are not some businesses out there, leading-edge businesses, who have not been at this point and perhaps who are beyond it.

Ms. FEDER. We can certainly look into that for you, Congressman. I think what is most critical, when we hear companies talking about what they have been able to achieve, a great deal of it has to do with their encouragement of more efficient delivery systems for their employees.

We have built that into this system in spades. Essentially, we are building on that experience extensively. We continue to, by allowing companies to self-insure, we believe we are continuing to

encourage that kind of development both in the corporate alliances as well as in the broader community pools.

So I think it is on the delivery system side that has much to do with this as well as the benefit structure.

Mr. HOEKSTRA. I would have to say I am disappointed that somewhere in the administration, with all the people that have worked on this program, they cannot send me a list of who they have benchmarked this program against in the private sector. And if they have not, I am very, very skeptical. Thank you.

Chairman WILLIAMS. The gentleman from Puerto Rico.

Mr. ROMERO-BARCELO. Good morning, Dr. Feder. Good morning.

Dr. Feder, I would like to ask you a little more about the uninsured. According to your charts, by 1998 there will be no uninsured. But how do you say you can give coverage through single payor under this system? How do you give coverage to those that work in the underground economy? What happens to those?

Ms. FEDER. Congressman, essentially everyone is expected to sign up for a plan and that is part of individual responsibility. But what may happen in some cases is that people may not. And they, too, will need care. That is why we want everybody participating.

When they arrive at a doctor or hospital for care, they will receive care. But at that point they will, they identify themselves and it becomes apparent if they have not enrolled that they need to enroll. And we have mechanisms, then, to see that they are enrolled and if there are penalties for not having enrolled in a timely fashion.

Mr. ROMERO-BARCELO. Will they be given coverage?

Ms. FEDER. They will be given care.

Mr. ROMERO-BARCELO. The other question I have is regarding the pressure of small companies, the hiring of small companies in terms of employees and in terms of average wage. You do not define the companies in terms of their net income. I would be very concerned to call a small company a company that has 60 employees at an average salary of $23,000 and that made $23 million in net revenues. I would not call that a small company, or $50 million. And we have those kind of companies at home.

I am suggesting there should be a definition, and included in the definition a limit to the net revenues.

Ms. FEDER. I hear your concern in that regard.

As you know, in raising the question, you do know the attention to which we have given to try to target the discounts to small companies who need those discounts and our particular concern has been to avoid raising labor costs. In the course of our deliberations, the other measures were considered and examined and I don't think we found a good or effective way to do that.

Mr. ROMERO-BARCELO. Let me suggest that somehow or other you have to address net revenues. Net revenues. As I said, it would be extremely unfair to have a company that is a marginal company making $1 million or $2 million who has 100 employees making $24,000 and they have to pay 7.9 percent; and you have another company making $50 million net revenue with 60 employees paying $23,000 and they have a lower premium. That would be very, very unfair.

Ms. FEDER. I hear your concern, Congressman, and if we could, we would be happy to hear if you have some suggestions on better ways to target our subsidies.

Mr. ROMERO-BARCELO. You know, I struggled to get all the territories included, and we have an equal access, the citizens, the citizens of the territories. And I have said we want equal access and we want to have equal responsibility.

Now I am concerned because now, all of a sudden, the territories we are excluded from this cigarette sin tax. Now, whose decision was that? Why was that decision made? Because I am concerned that having been excluded from the cigarette sin tax, and then having different definitions for the territories as to how their payments are going to be made, how the contributions are going to be made, that we might again—we might have equal access but we will not be treated as a State in terms of the Federal Government participation.

Ms. FEDER. Congressman, as we have discussed over the months, I believe that the guarantees that you were seeking in terms of the treatment of the citizens of territories as citizens has been addressed and I just want to, I hope, put your mind at ease with respect to that.

With respect to the tax policy, I would have to look into that further for you.

Mr. ROMERO-BARCELO. I would appreciate it. If I could get an answer as to how that came about, whose decision was it; why? Because both the Government of Puerto Rico and I have been very clear that since we are asking for equal treatment, we would expect to share equally in responsibilities. And because there is a definition of territories on how the formula is applied for the payment of the government, I am kind of concerned that this could be then used to say, wait a minute, you do not qualify for equal shares from the Federal Government as a State because you are not paying.

Ms. FEDER. I hear that I have not put your mind at ease and will continue to work to do that.

Mr. ROMERO-BARCELO. Thank you very much.

Chairman WILLIAMS. Thank you. Mr. Fawell.

Mr. FAWELL. Thank you, Mr. Chairman.

As I have looked at the chart here, and specifically at some reports, you have indicated that the net subsidies would be about $116 billion. Here, it is $117 billion, and they are called employer individual discounts, but it is still the same.

Previously, and these figures keep changing and maybe they will change more because the bill has not been introduced yet, there was $259 billion in offsets. The real subsidy gross cost was $419 billion, I believe, under previous figures that were given to us. And then minus $259 of offsets, you came up with $160 billion net subsidies. Now we are down to $116 billion net subsidies.

I am not sure just what the costs are. Realizing we have different years now involved, and you are stretching it out some so that some of the cost would appear in a year that otherwise—if we had started earlier, we would have a different five-year period, so I realize we have some ambiguities there. But I would like an explanation of what are the offsets that shrink the cost of subsidies for

business and other low-income individuals from roughly in the area of—well, before it was roughly $160 billion net cost, but there was $259 billion of offsets, so a big slug of the subsidies we do not see because we are looking at net subsidies. What are these offsets?

Mr. THORPE. Okay, first, with respect to earlier versus later estimates, it is, I think, important to recognize that what we are calling here our net discounts are, from the previous estimates versus the estimates that you see here, are almost exactly the same, and the reason is that we made two changes in the interim.

One is that, as I mentioned in my opening remarks, the phase-in time period is a little bit different, which affects the savings, if you will. The second difference is that we have updated and used the most recent estimates of inflation, the CPI, which is 3.5 percent, which is what we are using.

The CBO projection is 3.1 percent so we are using a higher number. We had been using 2.7. So that explains the difference in the $259 billion versus what we now have in offsets which is $188 billion.

Mr. FAWELL. One hundred and eighty-eight in offsets? What are these offsets?

Mr. THORPE. They fall into two groups. First, with respect to the medicaid population, there is—just for discussion purposes, I will break the medicaid population into two groups, the cash assistance population and the noncash population. And the noncash population are essentially those individuals that receive medicaid either because they are medically needy or because categorically they become eligible for services, pregnant women and children.

Those are individuals that under the President's plan would now receive coverage directly through the alliance. They would never flow into the medicaid program. They would just get coverage through the alliance now. States and the Federal Government are making payments today on behalf of that population.

So under the proposal, States would have a maintenance of effort for the noncash population that I just talked about for the services covered in the comprehensive plan. Covered services. So that States would, rather than making their payments today in the medicaid program, simply take those dollars, make the payments into the alliances, and the growth in payments would rise at the rate of our budgeted private growth.

Mr. FAWELL. Then there is the medicare also.

Mr. THORPE. Right. So that is the first group. It is truly an offset because——

Mr. FAWELL. If you could get to the answer, because I have another question I want to get to.

Mr. THORPE. Medicare is savings from the fact that individuals who are working today would now receive coverage for the enrollment year through the alliance. So in that sense, there is a savings to the medicare program.

Mr. FAWELL. Isn't that a shifting of cost, then, over to the employers?

Mr. THORPE. In my definition, a shift, an offset is truly a transfer, that is correct.

Mr. FAWELL. But the employers are taking a shift of cost from government.

The big question that I had in mind is, I would like to have the figures—I look at these figures and they are almost all savings. And in every deficit reduction Act I have ever seen in Congress, we always start out with savings which are nothing more than decreases in increases in spending. I have never seen them work. They have always flopped.

And then we add to the fact we have a program that is so good, government will be doing it so efficiently, we will save money. So it is always decreases of increases in spending, plus we do it so efficiently that we will save money. And for nine years in Congress I have seen those just fall on their face and flop.

I am more interested in figures that I have never seen, and that is I would like to know the gross premium costs—some call them taxes—on employers who have roughly 60 percent of the pie over here. The gross premium costs—and they are taxes, too, because they are not voluntary, are put on people and they have to pay it. And employees.

I think that until we know these figures, how much employers and employees are going to be taxed and have to pay in these premiums over this five-year period, we will never get a handle on this, and I think my constituents at least will never buy it without being able to make comparisons.

Then we have to add to that how much will State taxpayers be still obligated to ante up on this. Because we are really trying to cut down overall costs on health care coverage. And if you can give me those figures—perhaps if you cannot give them to me now, but I would like to have them as soon as possible.

Mr. THORPE. A couple of points. First, it is that, clearly, what we are providing here is a premium. They are payments for benefits received through the alliance. So in any definition that I am aware of, it is not a tax in any definition.

Mr. FAWELL. Well, I will call it a tax, you call it a premium.

Mr. THORPE. Well, the dollar figures, going back to my pie chart, there is $321 billion in premiums in 1994 dollars, and employers would pay 59 percent of that, households would pay 17 percent of that.

Third point——

Mr. FAWELL. I hope I can get the gross figures, though, over the five-year period that we are anticipating.

Mr. THORPE. I will give you a sense of what they are. I was going to my third point, and that is if you look at the change in business spending and the change in household spending over that five-year period of what we are projecting, it is that both households and business, as well as national health expenditures, will be lower than the CBO projections of national health expenditures for those sectors by the year 1999 after the program is phased in.

So we can provide you with what the change in business spending and household business spending is.

Mr. FAWELL. If I can have the actual gross numbers year-by-year that are anticipated. From my viewpoint, please understand, I consider these to be tax obligations that people are going to have to pay. That is what I am really looking at. Because I think we do have to understand these are mandated obligations upon people, whether we call them premiums or whether we call them taxes.

They have to pay it. And we should know what that gross figure in the best of estimates that we have over the five-year period——

Chairman WILLIAMS. The Chair grants the gentleman one additional minute. He has to get his question out so he can get his answer.

Mr. FAWELL. I thank the Chairman.

Mrs. ROUKEMA. Would the gentleman yield on that point?

Mr. FAWELL. Certainly.

Chairman WILLIAMS. Mrs. Roukema.

Mrs. ROUKEMA. In providing those gross numbers, I would also like to know what the assumptions are that go into the configuration of those figures.

Mr. FAWELL. Yes, that would obviously be of help, too.

Mrs. ROUKEMA. Please.

Ms. FEDER. It is our expectation to provide those to you shortly.

Essentially, when you raised earlier the question, Congressman, that you never see those savings materialize, essentially what we are talking about is people's capacity to buy services in a health care system that right now is an entitlement on our wallets. And what we are doing in terms of reforming the delivery system is changing that for public and private purchasers alike.

So when some of the expectations or some of the projections in terms of savings surprise you, we need to remember we are comparing them to a system that is essentially accountable to no one in the current environment.

So that by letting that—if we continue on the course we are today, we are all paying more premiums, all paying more for the health care we all must have. It is that projection we are aiming to change.

Mr. FAWELL. I guess I would feel better if I had more of a firm base and I knew the money was coming from someplace other than an expectation that by decreasing increasing in spending, we will be able to pay for this. That bothers me.

Chairman WILLIAMS. The gentleman's time has expired.

I have one additional question for the witnesses. I do want to make a point in advance of that, however, and the point is that if the Federal Government had some years ago, let us say 10 years ago, passed health care reform, and if the result of that health care reform was today's system, the American people would clear-cut the incumbents on election day.

The American people are fed up, angry, frustrated and out of patience with the current system, which is an absolute first class mess.

Do we have quality in America? Yes, for some people, with very high costs. There are doctors and nurses. Well-trained? Absolutely. Does everybody work hard and can we pin all the medals on the health care personnel for dedication? Absolutely, of course. The medical technology is fine. If you want to send your son or daughter to a good medical school, you have to come to America. All of these things are true. But the system itself, the management of the system itself, the inefficiencies, the cost shifting, the number of people that are not covered, the ripoffs that go on in the private sector, are outrageous. If the Federal Government ran a system

like this, you would throw us all out of office and we would deserve it.

Let me say that both the administration bill and the Cooper bill require the establishment of a single regional alliance in each geographic area. The insurance industry has criticized the exclusive nature of that and has recommended a more competitive system where you would have two or more alliances in each geographic area.

As I have tried to come to grips with what it is the insurance industry does not like about the President's plan, I have watched the ads on television but they do not give you the reasons. I have read the ads in the newspapers, they do not get at the reason the dislike of the proposed health care reform. As I have talked to insurance people, premium caps and the establishment of one alliance in a geographic area are the reasons they do not like the President's plan primarily.

We know why they do not like premiums caps, that is obvious. But would you respond to why the insurance industry's criticism, perhaps it is well-placed, the exclusive nature of the alliances? You can respond to it by defending the President's plan or perhaps you want to respond to it, Dr. Feder, by telling us why the insurance companies would like to have multialliances in each geographic area?

Ms. FEDER. Yes, I think the answer to the latter is what is most important. You know that, as you have just described eloquently, in the current marketplace we have tremendous insecurity, uncertainty, and a lot of it comes from the fact that in the current marketplace insurers are able to determine who gets coverage for what at what price. Insurance companies have in the current marketplace earned a tremendous reward from avoiding people when they get sick and only insuring them while they are healthy, and I think that is what is so frustrating and frightening to all of us.

By bringing people together into a common pool, we essentially eliminate that capacity to do what we call cherry picking, to avoid the risks. That is a major reason that we are putting, bringing people together into that purchasing pool.

If you divvy up the pools, let people pick and choose which pool they can be in, you go right back to the situation we are in today, where they can pick off the good risks and avoid the bad ones.

Chairman WILLIAMS. If the alliance, if the various multialliances had to offer the benefit package as prescribed and we had premium caps, how would cherry picking be possible? What mechanism would the alliances or the insurance companies that were administering them use to cherry pick?

Ms. FEDER. If you have voluntary alliances, whenever it is voluntary, you can be excluded or included in that pool depending on your risk status. So essentially in voluntary alliances we have today, that we know exist around the country, they work for employers as long as those employers' employees are healthy. When they get unhealthy, they are no longer in that alliance. They leave it.

At the same time, what you have is an——

Chairman WILLIAMS. Let me disrupt you. By voluntary alliances, you mean that the alliance itself can choose who would cover us?

Ms. FEDER. That is right, can essentially look for its membership and in that way create a selection problem. So even if we have the rules for plans by enabling the employers and the marketplace to segment themselves, we are back to——

Chairman WILLIAMS. Well, what if you had a requirement that did not allow that? In other words, we put the benefit package at a floor under which no alliance could go. We capped premiums and then gave the right to any citizen to belong to any alliance within its geographic area, any alliance of its choice of that citizen's choice? Then that would stop, would it not, the cherry picking by management?

Ms. FEDER. No, I think essentially there are still issues there that reflect the capacity to choose based on risk status. I think that the end issue here——

Chairman WILLIAMS. Marketing.

Ms. FEDER. Marketing is part of it. What happens essentially when we bring people together in a single pool, we are able to handle the enrollment, and I guess it does get into a marketing issue, essentially individuals are enrolling in a centralized fashion based on objective information. They are making the choices themselves. They are not being picked out and selected by an insurance company. The insurance company has no opportunity to do that.

Anything that segments that or that allows multiple entities essentially enables the marketing or other factors to produce a segregation or a fragmentation and I think that is what is troubling no matter what rules we put in place.

Chairman WILLIAMS. Let me give you an example. If Virginia, Maryland and the District of Columbia were a geographic area for purposes of my illustration here, and if we had four alliances within that geographic area, those alliances, let us assume through their marketing, could advertise.

Ms. FEDER. That is right.

Chairman WILLIAMS. The ones that manage to pick you off—Northern Virginia, Chevy Chase, and Bethesda—make money; the alliances that get stuck with parts of southern Virginia and the District of Columbia are going to be lucky to break even, is that the point?

Ms. FEDER. Well said. That is the problem. And even when you talk about trying to adjust across those alliances, it is putting a tremendous burden on our system to make that work once we have allowed it to happen.

Chairman WILLIAMS. I see.

Mr. THORPE. Two other quick points on that that I would make, is that the other factor here is that we really want to move attention and energy away from spending time trying to select people based on their risk and how healthy they are. Again, a lot of attention, expense and I think waste in the industry is spent on trying to self-select people who are healthy as opposed to managing and providing high-quality care.

If you take that equation out of what we are talking about, that is a big savings in how health plans and providers spend their time focusing on organizing health plans and do not spend time trying to find very creative ways of avoiding risk.

Chairman WILLIAMS. I took a couple of extra minutes. I will ask my Ranking Minority Member if she would like two minutes.

Mrs. ROUKEMA. Now, I am confused. Up until today we have been talking about a lot of macroeconomics of it and the macrophase of it, and now we are getting down to the micro.

I did not understand your last response to the Chairman. I thought the Chairman's question was excellently posed regarding the alliances and why we cannot have competition. I will use a good Republican word, "competition" among alliances within a regional group.

Chairman WILLIAMS. Is that a Republican word?

Mrs. ROUKEMA. That is a Republican word. I didn't hear you and Dr. Feder use it when we were talking.

Chairman WILLIAMS. I can remember when the flag used to be a Republican symbol; now competition is a Republican word.

Mrs. ROUKEMA. I take it back. Let me get back to my issue. I choose to use the word "competition". But I don't understand why you cannot have a competitive pool there with competitive alliances within the pool.

I think our understanding is that the alliance has to be composed of, to use your example, of Virginia, Chevy Chase and maybe portions of Washington, DC—in other words, you have to spread the community rating aspect of this. I mean, that is what we are really talking about. But you do not have to have a single alliance to do that.

You can have a multiple number of alliances, it seems to me. And I think that was the thrust of your first question, Mr. Chairman. And I will ask you to please amplify on it in written form. But it seems to me that you can get to reform of the insurance industry, which is what we are talking about, avoiding the cherry picking and, et cetera, and provide portability. Because I think at the heart of this whole argument is portability and no longer canceling for preexisting conditions.

You can get at that through other legislative means, as we are in the State of New Jersey, but you do not have to give a monopoly to an alliance in a region to get to that kind of reform.

Ms. FEDER. Well, you talked about getting back to community rating and that is spreading the risk and in response to the Chairman's question, what the industry wants is really to allow different rates in the different alliances, and that is what happens when you create competing alliances. They are not in the same pool, they are different pools.

That is the whole purpose of the alliance, is to create the pool. When you charge a community rate, you charge it for the population you are serving. That is your community and that is what the alliance is about.

I wanted to say I think that we do use competition. It is a good

Clinton Administration word, and let me tell you about where it is that we think that the competition needs to focus. The competition needs to be between plans all held to offering the guaranteed benefit package and seeking to get people to enroll in these plans because one is performing better than the other and giving better value for the dollar. That is where the competition needs to be. What we do with the alliance, what the alliance does is simply make the marketplace in which that competition can occur.

[The information follows:]

Principles of the Health Security Plan

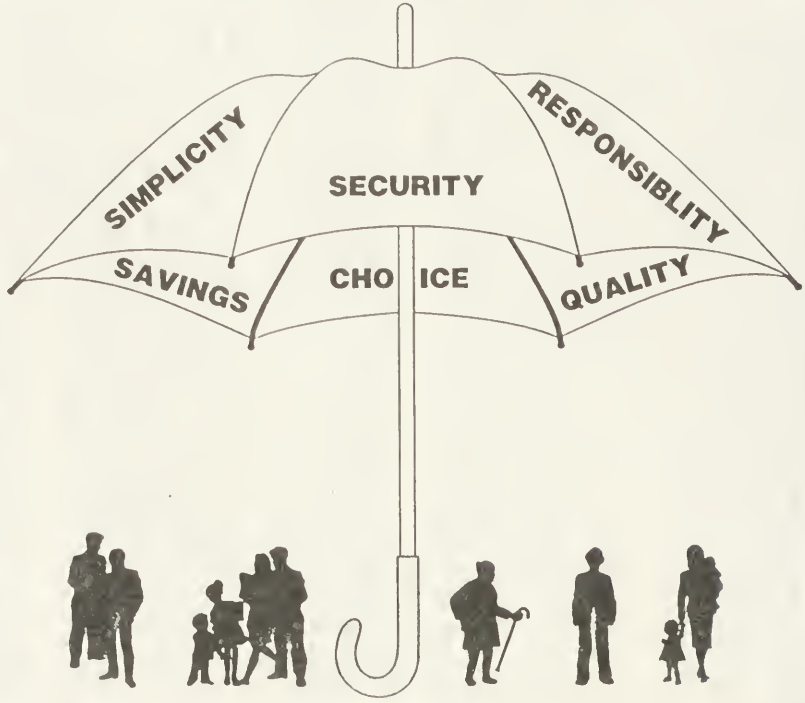
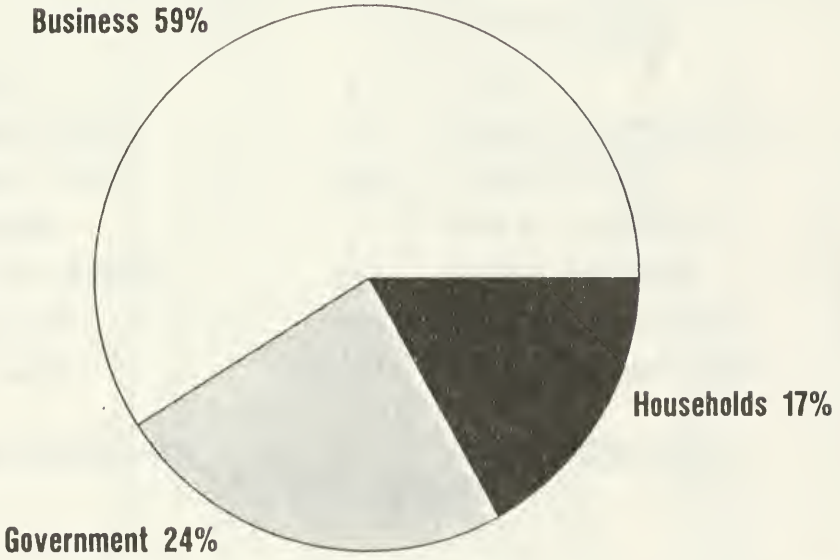


CHART 1

Source of Revenue for Premiums

Percent of Public and Private Premiums Under Reform



Source: HCFA, Office of the Actuary

CHART 2

Financing Health Care Reform

Sources of Federal Funds	
Medicare savings	$123.4
Medicaid savings	65.3
Tobacco tax/Corporate assessment	89.4
Other federal savings	39.6
Other revenue effects	68.1
Debt service	4.3
Total	**390.1**

Uses of Federal Funds	
Public health/Administration	$31.1
Long-term care initiatives	64.7
Medicare drug benefit	65.8
100% tax deduction for self-employed	9.7
Employer/Individual discounts	117.0
"Cushion"	44.1
Deficit reduction	57.7
Total	**390.1**

All figures in billions of dollars, fiscal years 1995-2000.

CHART 4

BENEFITS: THE HEALTH SECURITY PLAN COMPARED WITH CURRENTLY OFFERED PLANS

BENEFITS	HEALTH SECURITY PLAN		BLUE CROSS STANDARD, FEHBP	FORTUNE 500 COMPANY
	LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN[1]	HIGH COST SHARING (FFS)[2] / OUT-OF-NETWORK COMBINATION PLAN		
Medical Plan Maximum	No lifetime dollar maximum limit	No lifetime dollar maximum limit	Lifetime maximum for organ/ tissue transplants, mental health and substance abuse	Lifetime maximum for inpatient substance abuse
Out-of-Pocket[3]	$1500 / individual $3000 / family maximum	$1500 / individual $3000 / family maximum	$3000 / individual $3000 / family	$1,000 per covered individuals - does not include deductibles
Deductibles	None	$200 / individual $400 / family	$200 / individual $400 / family	$200/individual $400/family
Inpatient Hospital[4]	Full coverage, no coinsurance No dollar or day maximum	20% coinsurance no dollar or day maximum	$250 per admission deductible No dollar or day maximum	Full coverage in-network; 20% coinsurance out-of-network
Doctors Office Visits, Hospital Outpatient	$10 copay per visit No dollar or visit maximum	20% coinsurance no dollar or visit maximum	25% coinsurance	20% coinsurance
Outpatient Laboratory, Radiology, and Diagnostic Services	Full coverage	20% coinsurance	25% coinsurance	Full coverage in-network 20% coinsurance out-of-network
Emergency	$25 copay per visit, waived in emergency	20% coinsurance	Full coverage within 72 hrs. of accident	Full coverage - required plan notification within 48 hours
Preventive Services[5][6]	Full coverage, based on periodicity schedule	Full coverage, based on periodicity schedule	25% coinsurance 100% well childcare	not specified

1. SSI and AFDC recipients, and families with adjusted family income below 150% of the applicable poverty level, are eligible for reductions in cost sharing, if alliances determine that there are insufficient numbers of low or combination cost sharing plans available.

2. FFS - fee for service.

3. Deductibles counted toward out-of-pocket limits.

4. Mental health and substance abuse have separate provisions, see below.

5. Including well-child and prenatal care, periodic health exams, targeted tests and vaccines.

6. The National Health Board, in consultation with experts in clinical preventive services, will review and define specific services as preventive services for high risk populations, and will define appropriate periodicity schedules.

CHART 4 (cont.)

ENEFITS	LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN	HIGH COST SHARING (FFS) / OUT-OF-NETWORK COMBINATION PLAN	BLUE CROSS STANDARD, FEHBP	FORTUNE 500
Prescription Drugs	$5 per prescription	$250/year deductible 20% coinsurance	$50 deductible 40% coinsurance	20% coinsurance 50% coinsurance for drugs for treatment of mental or nervous conditions
Inpatient Mental Health (MH) and Substance Abuse (SA)[7]	Full coverage 30 day limit / episode 60 day annual limit	1 day deductible 20% coinsurance 30 day limit / episode 60 day annual limit	$250 per admission deductible; 40% coinsurance Unlimited days $3,000 maximum for substance abuse treatment program - 28 day max. $50,000 lifetime maximum	20% coinsurance pre-certification required Substance abuse: Full coverage in-network 20% coinsurance out-of-network; 30 days per stay, 2 stays maximum
Outpatient Mental Health	All outpatient except psychotherapy - $10 / visit Psychotherapy - $25 / visit; 30 visits annual maximum, 4 visits / 1 inpatient day at plan's discretion, beyond 30 visits Intensive nonresidential - full coverage; 120 day annual maximum. Available at plan discretion. first 60 days as trade against inpatient benefit; remaining 60 days subject to plan discretion	All outpatient except psychotherapy - 20% coinsurance Psychotherapy - 50% coinsurance; 30 visits annual maximum; 4 visits / 1 inpatient day at plan's discretion, beyond 30 visits Intensive nonresidential - 20% coinsurance; 120 day annual maximum. Available at plan discretion: first 60 days as trade against inpatient benefit; remaining 60 days subject to plan discretion	40% coinsurance; 25 visits annual maximum - includes partial hospitalization and visits for outpatient substance abuse $50,000 lifetime maximum	20% coinsurance for employee 50% coinsurance for dependent
Outpatient Substance Abuse	30 group therapy visits subsequent to treatment in inpatient or intensive nonresidential settings For individuals not initially treated on an inpatient or intensive nonresidential basis, 4 visits for 1 inpatient day trade	30 group therapy visits subsequent to treatment in inpatient or intensive nonresidential settings For individuals not initially treated on an inpatient or intensive nonresidential basis, 4 visits for 1 inpatient day trade	Subject to mental health limits	20% coinsurance; 30 visit maximum
Hospice for Terminally Ill	Full coverage	20% coinsurance	100% coverage for home hospice; $250 per admission for inpatient hospice with 5 consecutive day limit	Not specified

7. In 2001, inpatient and outpatient MH/SA limitations and higher cost sharing are phased out.

CHART 4(cont.)

BENEFITS	LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN	HIGH COST SHARING (FFS) / OUT-OF-NETWORK COMBINATION PLAN	BLUE CROSS STANDARD, FEHBP	FORTUNE 500
Home Health (HH)/ Extended Care (ECF - SNF and Rehab Hospitals)	Full coverage as inpatient alternative after acute illness or injury; 60 day reassessment 100 day annual limit extended care facilities	20% coinsurance as inpatient alternative after acute illness or injury 100 day annual limit extended care facilities	25% coinsurance 25 visit limit for home nursing care	20% coinsurance
Vision Care, Eyeglasses	$10 per exam, no additional copay for glasses Glasses limited to children only	20% coinsurance Glasses limited to children only	Not covered	Not specified
Dental Prevention and Treatment for Children Emergency Dental for Adults and Children[8]	$10 / visit	20% coinsurance; $50 deductible for treatment	Covered at fee schedule	Not specified
Prenatal Care	Full Coverage	Full Coverage	25% coinsurance	20% coinsurance
Outpatient Rehabilitation	$10 copay per visit; reassessed at 60 days for continuing improvement	20% coinsurance; reassessed at 60 days for continuing improvement	25% coinsurance 25 visit limit	Not specified
Home Medical Equipment	Full coverage	20% coinsurance	25% coinsurance	Not specified

8. In 2001, adult prevention and treatment, and orthodontia for severe malocclusion in children are added.

Cap on Small Firm Payments

Percent of Payroll

Average wage in thousands	Firm Size		
	Less than 25	25-50	50-75
Less than $12	3.5%	4.4%	5.3%
$12-15	4.4	5.3	6.2
$15-18	5.3	6.2	7.1
$18-21	6.2	7.1	7.9
$21-24	7.1	7.9	7.9
More than $24	7.9	7.9	7.9

CHART 5

Discounts for Individuals

Premium discounts

	Full-time Employees	Self-Employed	Unemployed	Early Retirees
80% Employer Share	Does not apply.	Contribution is capped as a percentage of self-employed income. ▪ The caps are the same as those applied to small businesses.	Discounts available for individuals whose family income is below 250% of poverty. ▪ Only non-wage earnings count as income; unemployment benefits do not. ▪ The first $1000 of earnings is not counted.	Federal government pays the 80% share for non-working early retirees.
20% Individual Share	Individuals and families with incomes below 150% of poverty are eligible for discounts. ▪ These discounts are on a sliding scale, based on income. ▪ The first $1000 of income is not counted. For families with total incomes below $40,000, the family share is capped at 3.9% of income.			

Cost-sharing discounts

For individuals receiving cash assistance and enrolled in a low cost-sharing plan, cost-sharing responsibilities are discounted by 80%.

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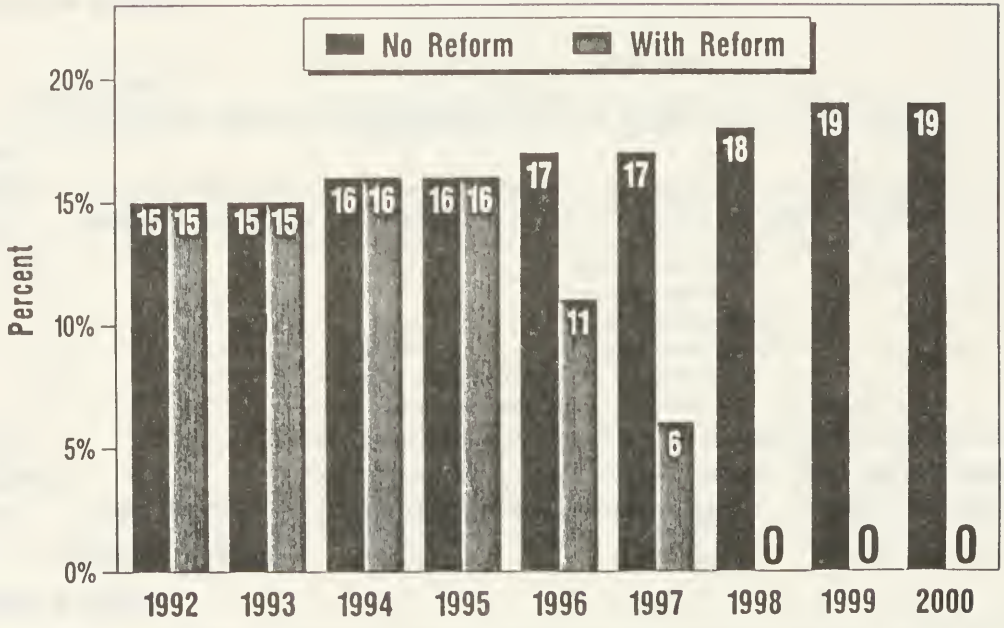
CHART 5(cont.)

Percentage of Americans Uninsured

By Year, 1992-2000

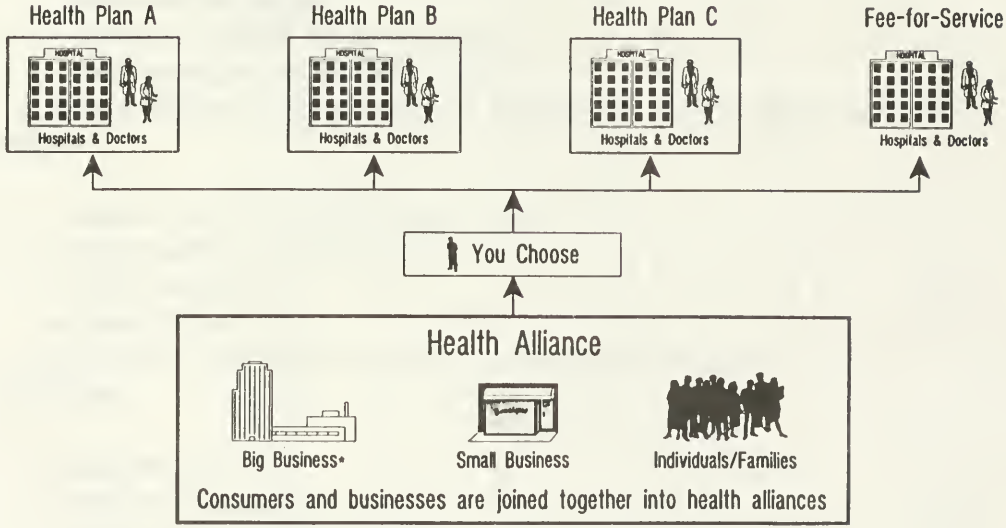


Source: HHS/ASPE projections

CHART 6

How You Get Coverage: The New System

Health care reform brings people closer to their doctors and the high quality, affordable care they deserve.



* Large businesses with 5000 or more employees may form their own corporate alliances.

CHART 7

Federal, State, and Alliance Responsibilities

The Federal Government

Sets the basic system framework

- Federally guaranteed benefits package
- Determines premium caps, increases, and enforcement
- Insurance reform

The States

Within federal framework, adopt health reform arrangement of choice

- Establish alliances
- Certify health plans
- Monitor quality of and access to care
- Implement insurance and malpractice reform

Alliances

Serve as collective purchasing agents for employers and consumers at the local level

- Solicit competitive bids from health plans
- Disseminate consumer information materials
- Enroll all eligible residents
- Collect premiums and pay health plans
- Administer employer and family discounts

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CHART 8

Mrs. ROUKEMA. I guess it seems to me you can do that legislatively without having—well, you are telling me the alliance is the regulatory body. Is that what you are telling me?

Ms. FEDER. No, I am saying it creates an opportunity for people; a place. You need some kind of organization of the market so that people can know what plans they are choosing among, sign up, collect the money, all those things. That is what making the market works means. But the competition is across plans.

Mrs. ROUKEMA. Dr. Feder, we do not want to keep you longer, but I will simply say in connection with this, as well as some questions that I have on the self-insured plans, I am going to submit in writing those questions because we do not have time today. But I would like you to address them in writing with some specificity because it seems to me under the present program the incentives are all for self-insured plans to give up and join the alliance.

I would just like to see—plus the definition of those self-insured plans, whether they have to be 5,000 or whether a Chamber of Commerce or some other industry cooperative could qualify as a self-insured plan. I would like that question answered.

I am also reminded by staff, if you will get the message back that some weeks ago we submitted some questions in writing to both Mrs. Clinton and Secretary Shalala, and I believe there may be one or two for Secretary Reich, and we have not gotten any responses. So if you could look into that, I would appreciate it.

Ms. FEDER. We would be happy to.

Mrs. ROUKEMA. Thank you. Appreciate your testimony.

Chairman WILLIAMS. Dr. Feder, Dr. Thorpe, thank you for being with us. You have been very helpful.

Ms. FEDER. You are welcome.

Chairman WILLIAMS. Thank you. The hearing is adjourned.

[Whereupon, at 10:55 a.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you Mr. Chairman. We have been waiting with great anticipation for the President's health care legislation. There are some minor changes which need clarification. But I do not wish to take away the fact that the President's proposal is the only proposal which defines benefits. By defining the guaranteed benefit package some of the mystery and doubt regarding the health care reform is moderated.

Also, the President's proposal provides caps on premiums for businesses and families. Premium caps will take away the largest fear of health care reform which my constituents have related to me, the unknown cost. Families are capped at 3.9 percent if their income is below a set annual salary. Both businesses and families must have a method of budgeting health care costs. Protection from increased or unknown cost is one of the primary reasons health care reform is taking place.

Another fear which is being used in some of the television spots now running is choice of physicians. Choice and the anticipated lack of choice of a person's health care provider under the President's proposal has become a push-button issue. I hope limiting the choice of health care provider is not the intent nor the effect of the administration's proposal. I believe most Americans have already limited choice through PPDs and HMOs. The President's proposal is one method for Americans to regain choice of health care providers without the unknown cost which currently exists.

Cost containment with guaranteed choice of health care provider must be part of the health care system reform. The President's proposal ends the use of preexisting conditions which prevents individuals from receiving total health coverage.

H.R. 3600—"THE HEALTH SECURITY ACT: VIEWS OF CONSUMERS AND INSURERS"

TUESDAY, NOVEMBER 9, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to call, at 10:10 a.m., Room 2175, Rayburn House Office Building, Hon. Jack Reed presiding.

Members present: Representatives Reed, Payne, Klink, Woolsey, Roukema, Gunderson, Ballenger, and Hoekstra.

Staff present: Phyllis Borzi, counsel for employee benefits; Jon Weintraub, staff director; Gail Brown-Hubb, staff assistant; Russ Mueller; Ed Gilroy; and Patrick Beers.

Mr. REED. Good morning, ladies and gentlemen. I would like to begin the hearing, and to state the obvious for us: I am not Pat Williams.

This morning, we will continue our hearings on health care reform. Although most Americans support the President's goals of security, simplicity, savings, choice, quality, and responsibility, considerable disagreement exists about the best way to achieve them.

Today, we will hear from a variety of organizations primarily representing consumers and insurers. Their views reflect the varying approaches, concerns and priorities that we will have to reconcile as Congress tries to craft a workable and affordable health care reform program.

Before we begin I would like to note that we had an unusually difficult time finding representatives of the insurance industry who are willing to testify before the subcommittee. I am disappointed—and I am speaking now on behalf of Mr. Williams—that we will not be hearing from a broader cross section of the insurance industry as we had hoped today, but we are particularly pleased that a few companies were able to be with us.

I want to welcome all of our witnesses. We look forward to your testimony.

At this time, Mrs. Roukema, what would you like to say?

Mrs. ROUKEMA. No, I have no opening statement. We have had enough of these hearings. I really have nothing more to say except what I have repeated over time, and they have been in the press, concerning the complexity, the cost factors, the questionable data, and the questions regarding the mandates for the Health Alliances in the individual States. I won't go into that again.

We do look forward to hearing from you. Unfortunately, I am going to be at a hearing on the Banking Committee where there

has been a subpoenaed witness. But I believe I will be able to return for the second panel.

However, I do want to assure each of the groups represented here today, including Citizens for a Sound Economy and possibly Families USA, generally I have heard from their perspective in my own district, particularly Consumers Union and the League of Women Voters. I have held a series of hearings, or meetings with representatives of each of the groups, and I do appreciate you being here and I will follow closely your testimony and follow up on it.

Thank you very much.

Mr. REED. Ms. Woolsey?

Ms. WOOLSEY. Thank you, Mr. Chairman. I just briefly want to appreciate the diversity of the panel we are going to be hearing today, and I think everybody knows I am a single-payer advocate. But something else that I want to see in our health care is reproductive services, and I understand we are going to hear more about that today, and I really welcome the panel.

Mr. REED. Mr. Ballenger?

Mr. BALLENGER. I have no opening statement, Mr. Chairman.

Mr. REED. Thank you. Mr. Green, do you have an opening statement?

Mr. GREEN. No, Mr. Chairman. Thank you.

Mr. REED. The first panel consists of Becky Cain, President of the League of Women Voters; Gail Shearer, Manager for Policy Analysis of the Consumers Union; Michele Davis, Health Care Economist, Citizens for a Sound Economy; and Ron Pollack, Executive Director of Families U.S.A.

And, Ms. Cain, if you would begin, please.

STATEMENTS OF BECKY CAIN, PRESIDENT, LEAGUE OF WOMEN VOTERS; GAIL SHEARER, MANAGER FOR POLICY ANALYSIS, CONSUMERS UNION; MICHELE DAVIS, HEALTH CARE ECONOMIST, CITIZENS FOR A SOUND ECONOMY; AND RON POLLACK, EXECUTIVE DIRECTOR, FAMILIES U.S.A.

Ms. CAIN. Certainly.

Mr. Chairman, members of the subcommittee, I am Becky Cain. I am President of the League of Women Voters of the United States.

I am very happy to be here today to comment on President Clinton's health care reform plan.

The League of Women Voters is a nonpartisan citizen organization with approximately 200,000 members and supporters nationwide. In the health care system we have been concerned as League members for many years. In 1990, we began a 3-year intensive study on the delivery and financing of health care in the United States. Leagues and League members across the country carefully examined the problems and considered solutions to the health care crisis.

After thousands of hours of grassroots debate, League members reached a consensus on health care reform. The consensus is the basis of my testimony today.

The League of Women Voters believes that fundamental health care reform must provide universal access to quality health care for

all U.S. residents regardless of ability to pay and must include stringent cost control measures for health care reform.

In a recent national public opinion poll, Americans ranked health care as the most important issue for citizens to get involved in, more important even than the economy and the environment. Health care is on the mind of every citizen in America today, and the League of Women Voters wants to ensure that the concerns of citizens are on the mind of every legislator involved in shaping tomorrow's health care system.

As citizens, we say to you, our elected Representatives, as clearly and as forcefully as we can: Fix these problems. Pass comprehensive health care reform.

The League of Women Voters believes that President Clinton's health care reform package makes a critical step forward. It will fix fundamental flaws in our Nation's health care system. It is real reform.

Under the plan, Americans will be covered no matter where they live, where they work, or how much they earn. The plan's basic benefits package will be a boon to people's health. For the first time, all Americans will be guaranteed coverage for preventive, primary and acute care, and reproductive health services, including abortion, are in the plan. Mental health services and long-term care are also included but are limited to keep costs down.

Among the plan's most critical features are its built-in cost control mechanisms. By standardizing forms, introducing new competitive structures, and limiting spending, the plan has effective ways of cutting waste and reducing costs.

The President's health care plan is not perfect, but it is fair. It will need some fine tuning in the legislative process. For example, citizen and consumer participation must be included in all aspects of the plan's implementation to ensure that government-sponsored programs are responsive to people's needs.

The administration of the health care system must be a process in which citizens can express their views and participate. We believe that State and Federal programs, and especially the Health Alliances, should follow the Federal policy of open government, including open meetings, full access to information, open regulatory processes, adequate comment periods, and other protections to make sure that citizens are involved and aware.

The health system must also be responsive to the needs and perspectives of people as consumers. We believe that the Health Alliances should, as stated in the plan, disseminate information to consumers regarding quality and access, prepare comparative reports on the quality of health care plans, providers and practitioners, and conduct education programs to assist consumers in choosing their health care plans.

Health reform will need bipartisan support. The League is encouraged that many of the goals for reform are now shared by key members of both political parties on Capitol Hill. Congress must not lose sight of the cost of inaction on this critical issue. Americans cannot afford a protracted political battle on national health care reform.

There will be no perfect solution to this crisis. Not everyone will get everything they want. But for once everyone has the possibility

of getting what they need. This in itself will be a giant step forward.

We need a viable plan that gives all Americans a more humane health care system. The President's plan is an effective blueprint. Congress must now seize the momentum. There can be no turning back. It is time to forge ahead and enact comprehensive reform.

Thank you.

Mr. REED. Thank you very much, Ms. Cain.

[The prepared statement of Ms. Cain follows:]

TESTIMONY BEFORE THE

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

OF THE HOUSE EDUCATION AND LABOR COMMITTEE

ON

PRESIDENT CLINTON'S HEALTH CARE REFORM PLAN

BY BECKY CAIN, PRESIDENT

THE LEAGUE OF WOMEN VOTERS OF THE UNITED STATES

November 9, 1993

Mr. Chairman, members of the subcommittee, I am Becky Cain, president of the League of Women Voters of the United States. I am very happy to be here today to comment on President Clinton's health care reform plan. I would also like to discuss the critical need for comprehensive health care reform and to outline the League's views on what should be included in any effective reform plan.

The League of Women Voters is a non-partisan citizen organization with approximately 200,000 members and supporters in all fifty states, the District of Columbia, Puerto Rico and the Virgin Islands. For almost 75 years, Leagues across the country have worked to encourage the informed and active participation of citizens in government. The League is expert at giving citizens the tools necessary to make important decisions on critical public policy issues.

The health care system has concerned League members for many years. In 1990, we began a three-year intensive study on the delivery and financing of health care in the United States. Leagues and League members across the country carefully examined the problems and considered solutions to the health care crisis. After thousands of hours of grassroots debate, League members reached consensus on health care reform. That consensus is the basis for my testimony today.

The League of Women Voters believes that fundamental health care reform must provide universal access to quality health care for all U.S. residents regardless of ability to pay and must include stringent cost control measures for health care outlays.

It is clear that our current health care system is failing. It is failing our nation's families and it is failing our nation's

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202/429-1965 FAX 202/429-0854

economy. Millions of Americans are losing the battle to keep up with rising health care costs. As a nation, we spend $1 out of every $7 we earn on health care. Families feel uncertain about their ability to afford adequate care. An extended hospital stay or long-term care for aging parents can deplete any family's budget. Our nation's businesses cannot compete in a world economy, and we cannot assure good-paying jobs, when health care costs are spiralling out of control.

For those who cannot afford health insurance -- and 37 million people have no health insurance -- the picture is even more grim: no doctor when one is needed, no medicine when illness strikes. Something is fundamentally wrong when mothers can't afford prenatal care, when children don't receive routine vaccinations, when working families can't afford health insurance, and when older parents are left destitute without adequate long-term care.

In a recent national public opinion poll, Americans ranked health care as the most important issue for citizens to get involved in -- more important even than the economy and the environment. Health care is on the mind of every citizen in America today. And the League of Women Voters wants to ensure that the concerns of citizens are on the mind of every legislator involved in shaping tomorrow's health care system.

As citizens, we say to you, our elected representatives, as clearly and as forcefully as we can: Fix these problems; pass comprehensive health care reform.

The League of Women Voters believes that President Clinton's health care reform package marks a critical step forward. It will fix fundamental flaws in our nation's health care system. It is real reform.

Under the plan, Americans will be covered no matter where they live, where they work or how much they earn. The plan's basic benefits package will be a boon to people's health. For the first time, all Americans will be guaranteed coverage for preventive, primary and acute care; and reproductive health services, including abortion, are in the plan. Mental health services and long-term care are also included, but are limited to keep costs down.

Among the plan's most critical features are its built-in cost control mechanisms. By standardizing forms, introducing new competitive structures and limiting spending, the plan has effective ways of cutting waste and reducing costs.

The President's health care plan is not perfect but it is fair. It will need some fine-tuning in the legislative process. For example, citizen and consumer participation must be included in all aspects of the plan's implementation to ensure that government-sponsored programs are responsive to people's needs.

The administration of the health care system must be a process in which citizens can express their views and participate. The League of Women Voters is opposed to the administration of the health care system solely by the states. We support administration of the health care system by a combination of federal, state and/or regional government agencies. We

believe that any health reform plan must provide for a strong federal role.

It is important that state and federal programs, and especially the health alliances that will be created as the result of health care reform, should follow the federal policy of open government, including open meetings, full access to information, open regulatory processes, adequate comment periods, and other protections to make sure that citizens are involved and aware.

The health system must also be responsive to the needs and perspectives of people as consumers. We believe that health alliances should, as stated in the President's plan, disseminate information to consumers regarding quality and access; prepare comparative reports on the quality of health plans, providers and practitioners; and conduct education programs to assist consumers in choosing health plans. We support the provisions for including consumer representatives at many levels of the President's plan.

In short, we believe the President's plan is an effective blueprint for health care reform and we urge its speedy consideration.

I would like to take a few minutes to outline the League's views on several key points that we believe should be included in any health care reform plan.

First, a reform plan must achieve universal coverage for all U.S. residents. Reform must establish a basic level of quality health care regardless of ability to pay.

Universal access is the basic test of the humanity of our health care system. The most advanced nation on earth must be able to assure adequate health care for all. We are particularly concerned that all plans, including President Clinton's, meet this test. The League of Women Voters believes that universal coverage is the key to successful health care reform and we will be looking very carefully at the effect of caps on subsidies to low-income workers.

Universal access is also important as a cost control measure. Under the present system, cost shifting occurs when uncompensated care for the uninsured is passed along to the rest of us in the form of higher prices. In addition, illnesses left untreated because people don't have insurance are much more expensive to cure when someone finally goes to the emergency room.

How can universal coverage be achieved? The League favors a national health insurance plan financed through general taxes -- a so-called "single-payer" plan. We also believe that an "employer-mandate" system is acceptable.

Under an employer-mandate system, employers would be required to pay most of the costs of purchasing health care coverage for their employees and their families, who would pay the balance. The government would pay for those who are not in the work force, while small businesses would receive subsidies to assist them in providing coverage.

Because it builds on the existing system, under which most people get health insurance coverage through their family's employment, an employer-mandate system can achieve universal access without large disruption of the health care delivery system. In addition, because health care is a traditional form of compensation, and because it assures a healthy and productive workforce, it is appropriate for employers to continue to pay for health care.

Some have proposed that universal access be accomplished by requiring individuals to purchase health insurance. Often these proposals also provide tax incentives to encourage participation. Because such a system is very difficult to enforce, and because the type of coverage in such proposals is usually very spartan, this method can fall short of providing universal access to quality care. The League does not support such proposals.

Another important access issue is the problem of underserved areas. Too often, quality health services are not available in rural areas or inner cities. It is critical that the United States allocate resources to underserved areas and train health care professionals in needed fields.

The second crucial issue for any health care reform plan is the type of coverage that is included. The coverage must be broad and inclusive enough to protect people's health. But coverage must be limited to ensure that costs are not excessive. Striking the proper balance is one of the most difficult issues in the health reform debate.

The League of Women Voters believes that a basic package of quality services should include the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health services), acute care, long-term care and mental health care. Dental, vision and hearing care are also important but lower in priority.

Primary care, the general "wellness" care received by a patient, is critical. Currently, the lack of primary and preventive care often results in serious illness and expensive medical intervention. By providing care such as prenatal care to all pregnant women and routine vaccinations to all children, we can save lives and money.

Acute care, the treatment of illnesses or injuries, is also critical. Providing this care to all U.S. residents would reduce cost shifting and help control costs, in addition to ensuring better health for all.

As Americans live longer, the need for long-term care is a reality for almost every family. Long-term care for persons who are chronically ill or mentally or physically disabled is also essential. Our current infrastructure for long-term care, however, is lacking. We need to look for new ways to deal with these problems, such as care in the home, that are not exceedingly expensive. In any case, a start must be made on long-term care.

A start must also be made on mental health care. It is abundantly clear that mental health care pays real dividends in lives saved, in pain relieved, in families assisted and in workers helped to remain productive.

I would like to say a few words about abortion services. We believe that abortion services must be included in the standard benefits package, just like any other safe, effective and legal medical procedure. A woman and her doctor must make the difficult decisions about reproductive health care -- Congress has no business making those decisions. Generations of women and men have fought to ensure access to safe abortion services. Such services are now included in many women's existing health plans. Make no mistake, removing abortion services from the benefits package would take away something fundamental from women across the country.

The third key issue in health care reform is cost control. A simple look at the numbers illustrates the problem. Between 1980 and 1991, the total amount spent on health care per family more than doubled. Without strong action, it will more than double again by the year 2000. America's families can't afford this and neither can America's businesses.

The League believes it is absolutely essential to achieve a reasonable total national expenditure level for health care. In order to control costs, legislation to reform the health care system should include specific cost-cutting measures such as:

- o the reduction of administrative costs;
- o regional planning for the allocation of personnel, facilities and equipment;
- o the establishment of maximum levels of reimbursement to providers;
- o malpractice reform;
- o the use of managed care;
- o utilization review of treatment;
- o mandatory second opinions before surgery or extensive treatment; and
- o consumer accountability through deductibles and copayments.

Such techniques hold real promise for controlling costs. According to some estimates, at least $130 billion a year is spent on unnecessary care. Managed care, which is designed to limit inappropriate or excessive utilization of health care services, can provide more efficient and economical delivery of care. Increased consumer accountability through deductibles and copayments can also help cut overutilization.

With 24 cents of every health care dollar going to administrative costs, it is apparent that administrative procedures must be streamlined, resulting in substantial savings. In Canada, which uses a single-payer system, the cost is 11 cents of every dollar. It is also vitally important to reduce duplication of services, facilities and equipment, such as costly, high-tech diagnostic machines.

In addition to specific cost control techniques, however, health care reform must include an overall mechanism to ensure that savings add up. There must be a back-up mechanism to oversee and coordinate cost-cutting efforts. We think that global budgeting can provide that needed mechanism. National and regional boards comprised of policy makers, medical professionals, and consumers could set goals or limits for spending

at the national, state and local levels. Governments and health providers would then operate within those limits. Careful consideration needs to be given to how global budgeting will operate. We need to make sure that cost controls are consistent with quality and are not arbitrarily imposed. But the need for such global budgeting is clear. We believe it should be included in health care reform legislation.

The fourth and key issue in health care reform is how to pay for it. Substantial savings can be achieved over the current health care system, and these savings should be applied to ensuring that all U.S. residents have a basic level of quality health care. No doubt a large part of the debate over the next several months will be over the size of those savings. Whatever the outcome, however, we believe that the goal of universal access is worth paying for. That is why we support increased taxes to finance a basic level of health care for all, provided effective cost control strategies are employed.

The League looks at a variety of factors when evaluating the acceptability of taxes, but we are particularly concerned that the overall health care reform package is fair, equitable and progressive. The League would support a general income tax increase to finance national health care reform and could support restrictions on the deductibility of health care benefits. We strongly oppose a value added tax (VAT) or national sales tax. This is a highly regressive tax and would unfairly burden low and middle-income Americans.

The League does support increases in so-called "sin taxes" on such products as cigarettes and alcohol as part of a reform package that encourages Americans to lead healthy lifestyles. Such taxes discourage the excessive use of these harmful products and will actually serve as "preventive medicine."

In summary, the League of Women Voters calls on Congress to enact national health care reform that provides for universal access to quality health care and for stringent cost control measures.

Health care reform will need bipartisan support. The League is encouraged that many of the goals for reform are now shared by key members of both political parties on Capitol Hill. Congress must not lose sight of the costs of inaction on this critical issue. Americans cannot afford a protracted political battle on national health care reform. There will be no perfect solution to this crisis. Not everyone will get everything they want. But, for once, <u>everyone</u> has the possibility of getting what they <u>need</u>. This, in itself, will be a giant step forward.

We need a viable plan that gives all Americans a more humane health care system. The President's plan is an effective blueprint for reform.

Congress must now seize the momentum. There can be no turning back. It is time to forge ahead and enact comprehensive health care reform.

Mr. REED. Ms. Shearer?

Ms. SHEARER. Thank you.

Consumers Union appreciates the opportunity to present our views on the Clinton administration's proposal for health care reform. Consumers Union's efforts in support of health care reform go back many years.

In 1939, over 50 years ago, our article—and this is in the February 1939 issue of Consumer Reports—concluded, "It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country is how soon?"

It is time for us to finally end the Nation's health care nightmare and answer the question now. Consumers cannot and should not have to wait longer for a solution to the health care crisis.

Consumers Union is eager to help you to analyze the elements of health care reform from the consumer perspective. As your subcommittee helps lead the Congress' consideration of the reform plan, we urge you to also keep in touch with the average American consumer, the people whose lives are either improved by a health care system that works well or whose lives are destroyed by a health care system that fails them. Only by keeping in touch with these consumers will the Congress be able to stand up to the many special interests that will seek to make their case in order to develop a health care program that meets consumers expectations and needs for health care reform.

To meet the needs of consumers, any health care reform must offer universal quality health care with comprehensive benefits, cost containment, fair share financing, public accountability and consumer choice of health care providers.

While we continue to believe that a single-payer health care system could best meet the health care needs of American consumers, we are pleased that the Clinton administration has embraced many of these principles. We believe that the Clinton proposal would move the Nation's consumers closer to health care security. Still it leaves room for significant improvements.

The strongest part of the health plan is its commitment to universal health care protection. The Nation can no longer rely on the free market and wishful thinking when it comes to health care security.

Health care is not a commodity like detergent and VCRs that can be bought and sold in the marketplace. While the free market works well for things we buy at K–Mart, it utterly fails when it comes to surgery, check-ups and other health care services.

The proposal, if enacted, would offer relief to the millions of Americans who are now denied protection due to their financial status or preexisting conditions. The plan offers security to everybody against unforeseen events such as development of serious illness or loss of jobs.

I plan to focus on 10 important consumer issues, areas where the health security Act needs to be improved or important provisions need to be defended against special interests.

The Clinton health care proposal makes a good start at providing consumers with health care security. Now, the first point is that there is a need to protect low- and middle-income consumers from

paying a disproportionately high share of health care costs, and the best way to protect consumers is to cap the employee's contribution toward the 20 percent of premium at 2 percent of income, and to reduce the cost-sharing requirements for low-income consumers.

Second, the plan should encourage the State single-payer option. The Health Security Act allows States to establish a single-payer health care system, a very important provision that allows States the option of implementing reform through a system that is universal, contains costs, is fairly financed, is accountable to the public, and allows full consumer choice of provider.

Third, make freedom of choice of provider a real option for people of all income levels by requiring all Health Alliances to offer a fee-for-service plan that costs little more than the average cost plan. This change is needed because freedom to choose their health care provider is one of the most highly valued features that consumers seek in their health care system. The inclusion of the point-of-service option for consumers enrolled in HMOs is an important new feature of the Act. It provides peace of mind to consumers who enroll in a health plan and later find their needs have changed.

Fourth, include the blueprint for phasing in nursing home benefits and expanded community care benefits. We recognize, as should the Congress, that these benefits will require a substantial new funding base, and we recommend that you consider increasing taxes to pay for the expanded long-term care benefits.

Fifth, give the National Health Board the authority to regulate prescription drug prices that apply to all Americans, not just the medicare and medicaid eligible. When it comes to the regulation of prescription drug prices, we believe that the administration plan should be strengthened to include the authority to regulate prescription drug prices. If drug prices were a river, they would already be well above flood stage. It is meaningless to talk about voluntary price controls since prices are already so out of line.

The October issue of Consumer Reports, which we have provided to each Member of Congress, has an article that provides details of the unnecessarily high prescription drug prices.

Briefly, the sixth area is universality must be a reality by 1997 and should not be dependent on voluntary participation or cost savings.

Seventh, both public and private spending must be subject to stringent cost containment both to achieve savings and to avoid cost shifting.

Eighth, the number of employees needed to form a corporate alliance should not be expanded beyond 5,000.

Ninth, the most severely injured victims of medical malpractice must be protected. Proposed caps on damages do not produce savings, according to the Congressional Budget Office.

And finally, the benefit package must remain comprehensive. This is what consumers want and need, and it is crucial to avoid a burgeoning supplemental market and a multi-tiered health care system.

Thank you.

Mr. REED. Thank you very much, Ms. Shearer.

[The prepared statement of Ms. Shearer follows:]

GAIL SHEARER

SUMMARY
CONSUMERS UNION'S TESTIMONY
ON THE CLINTON ADMINISTRATION'S HEALTH CARE PROPOSAL
November 9, 1993

Consumers Union continues to believe that a single-payer health care system would best meet the consumer principles of:
-- universal, quality health care with comprehensive benefits;
-- cost containment;
-- fair-share financing;
-- public accountability; and
-- consumer choice of providers.

The Clinton health care proposal embraces most of these principles and would move the nation's consumers closer to health care security.

Important areas for Congressional consideration--and holding the line against special interest requests to weaken the proposal--include the following:

-- protect low- and middle- income consumers from paying a disproportionately high share of health care costs by capping the percent of income spent on the employee's share of premium, and by making sure that cost-sharing does not present a financial barrier to receiving care;
-- encourage the state single-payer option, as allowed by the Act;
-- make freedom-of-choice of provider a real option for people of all income levels by limiting the differential above the average cost plan;
-- include the gradual phase-in of nursing home benefits and expanded community long-term care benefits;
-- strengthen regulation of prescription drug prices to include all prescription drugs;
-- universal health care must be a reality by 1997, and should not depend on cost savings or "voluntary" participation by employers;
-- cost containment through global budgets on both public and private spending must be preserved;
-- the employer opt-out must not be expanded for employers with fewer than 5000 employees and participants in corporate alliances must pay their fair share of system costs and be subject to the same consumer protection requirements.
-- victims of medical malpractice must be fairly compensated for their injuries; and
-- the benefits package must stay comprehensive.

Consumers Union[1] appreciates the opportunity to present our views on the Clinton Administration's proposal for health care reform. Consumers Union's efforts in support of health care reform go back many years. In 1939, Consumer Reports noted that forty million Americans received inadequate medical care and called for enactment of the Wagner National Health Bill, which would have been a "cornerstone for a national health program."[2] In 1946, Consumer Reports supported the Wagner-Murray-Dingell Bill, which would have established federal compulsory health insurance.[3] In 1975, Consumer Reports published a comprehensive comparison of five proposals for national health insurance and established five goals that a national health insurance plan must meet to serve the consumer interest. Consumer Reports published a two-part series, "The Crisis in Health Insurance" in 1990, and a three-part series in 1993 that reviewed wasted medical care dollars, consumer satisfaction with Health Maintenance Organizations, and solutions

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[1]Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2]"The Wagner Bill and mr. Gannett," Consumer Reports, April 1939, p. 20 and "By Popular Demand," Consumer Reports, February 1939, p. 32.

[3]"Bureaucracy in Medicine?," Consumer Reports, April 1946, pp. 110-111.

to the health care crisis.

In 1939 -- over fifty years ago -- our article concluded: "It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'" It is time for us to finally end the nation's health care nightmare and answer this question "now!" Consumers can not and should not have to wait longer for a solution to the health care crisis.

Consumers Union is eager to help you to analyze elements of reform **from the consumer perspective.** As your Subcommittee helps lead the Congress's consideration of the reform plan, we urge you to also keep in touch with average American consumers -- the people whose lives are either improved by a health care system that works well, or whose lives are destroyed by a health care system that fails them. In developing its health reform proposal, the Clinton Administration was successful in reaching out to the consumers who are on the receiving -- or non-receiving -- end of health care in America.

Only by keeping in touch with these consumers will the Congress be able to stand up to the many special interests that will seek to make their case, in order to develop a health care program that meets consumers' expectations and needs for health care reform.

CONSUMER PRINCIPLES FOR HEALTH CARE REFORM

To meet the needs of consumers, any health care reform plan must offer:

universal, quality health care (with comprehensive benefits) for all U.S. residents -- regardless of age, income, employment status or health status);

cost containment with a national health care budget and control over wasteful paperwork and procedures;

fair-share financing with savings from cost containment as a central funding source and additional funding obtained on a fair and equitable basis;

public accountability with consumers well represented on all boards overseeing health care; and

consumer choice giving consumers the freedom to choose where they will go for health care and who will provide it.

While we continue to believe that a single-payer health care system could best meet the health care needs of American consumers, we are pleased that the Clinton Administration has embraced many of these principles. We believe that the Clinton proposal, which is premised on universality through an employer mandate, would move the nation's consumers closer to health care security. Still, it leaves room for significant improvements.

THE CLINTON HEALTH CARE REFORM PLAN

A CONSUMER PERSPECTIVE

We have evaluated the Administration's draft health care reform plan (dated September 7, 1993) against the five consumer

principles listed above, and we are in the process of reviewing the Health Security Act that was released on October 27, 1993. Attached to this testimony is our analysis of the draft plan (including a summary). When we have completed our analysis of the recently released legislation, we will submit it to the Subcommittee.

The strongest part of the health plan is its commitment to **universal health care protection.** The nation can no longer rely on the "free market" and wishful thinking when it comes to health care security. The proposal -- if enacted -- would offer relief to the millions of Americans who are now denied protection due to their financial status or to pre-existing conditions. The plan offers security to everybody against unforeseen events such as development of serious illness or loss of jobs.

The Clinton health care proposal incorporates elements that we have long supported, including (1) a standard, comprehensive benefit package for all Americans; (2) control over health care premiums set by the National Health Board, rather than the free market; (3) a prohibition of balance billing, and (4) rejection of caps on damages for victims of medical malpractice. The attached analysis explores in more detail both the strengths and the weaknesses of the Clinton draft proposal.

In the remainder of my written testimony, I will summarize our comments by presenting ten areas where we recommend that the Administration and Congress take care to put the consumer interest first and defend the plan against attack and erosion from special

interests.

PROTECTING CONSUMERS: AREAS FOR FOCUS

The Clinton health care proposal makes a good start at providing consumers with health care security. The following ten areas are of critical importance to the success of the health care reform plan meeting consumer needs.

1. Protect low- and middle- income consumers from paying a disproportionately high share of health care costs.

This is an area where the legislation released on October 27 has improved significantly on the draft plan of September 7, 1993, but further protection of low and middle-income consumers may be needed. Low- and middle- income consumers need protection against high out-of-pocket health costs and high premiums. The Clinton health care plan goes a long way to providing this protection. An important new feature in the legislation is limit of percent of income that must be spent on the family share of the premium. The proposed limit is 3.9 percent of income. We have supported a 2 percent limit, and are reviewing the impact of the 3.9 percent limit.

The legislation also provides the details of the premium discounts for low-income families. Discounts cover the entire premium for the poorest families, and are phased-out once family income reaches 150 percent of poverty. Families in the income range of $5000 to $20,000 could pay about 2.5 percent to 3.9 percent of their income on premiums, and possibly more if they choose a higher-than-average health plan.

The legislation also includes important new protection for low-income consumers against the potentially high burden of cost-sharing. Section 2105 prohibits cost sharing (other than nominal cost sharing) for individuals with income level less than 150 percent of poverty.

2. Encourage the state single payer option.

This is a second area where the legislation released on October 27 significantly improves on the September 7 draft. The Health Security Act now provides states a real option to implement the reform through a single payer system, and eliminates several burdensome hurdles that were in the earlier draft. We believe that the single payer option is the best option for states; states that opt for a single payer system will provide their residents with a system that is universal, contains costs, is fairly financed, is accountable to the public, and allows full consumer choice of provider.

3. Make freedom-of-choice of provider a real option for people of all income levels by requiring all health alliances to offer a fee-for-service plan that costs little more than the average cost plan.

Freedom to choose their health care provider is one of the most highly valued features that consumers seek in their health care system. Consumers want to be able to continue long-standing relationships with their family doctors, specialists, pediatricians, and other health care providers. Often, one family will have an array of doctors, making it impossible to follow them

all to one HMO. Consumers want to be assured that if serious illness strikes, they will have access to the highest-quality specialist and specialized treatment centers.

All consumers -- even those that can afford the fee-for-service option -- face considerable uncertainty about whether their current doctors will be available to them. We are concerned about the possibility that freedom of choice of provider could be a luxury only the rich can afford. We recommend that in negotiating for a fee-for-service health plan, health alliances should be required to make this option available to all, by limiting the premium differentials (above the average cost plan) that can be charged by fee-for-service plans.

The Health Security Act has a provision that was not included in the earlier draft that will serve to provide an added level of freedom of choice for consumers: the Act will allow consumers that want to seek treatment outside of their health plan to do so, under a "point of service" option. We expect that this will be an extremely valuable option for many consumers who are interested in enrolling in an HMO, but want to continue to see one or more providers that are not part of that HMO. It also provides peace of mind to consumers who enroll in a health plan and then later in the year (when serious illness strikes) find that their needs have changed and they want access to the best specialist in the field, who may not be part of that HMO. This is an important feature of the plan to retain.

4. Include the blueprint for phasing-in nursing home benefits and expanded community care benefits.

The United States faces a growing long-term care crisis that will only get more severe as the population ages. Consumers Union has concluded that the private insurance market is incapable of solving the nation's long-term care problem -- it will never cover people who can not afford the high premiums, nor will it protect people whose pre-existing conditions make them uninsurable. The draft health plan includes an important community based care benefit. But the requirement that potential beneficiaries must be unable to perform three "activities of daily living" limits the benefit to a small portion of people in need of long-term care. For example, a person incapable of moving around (e.g., from bed to a chair) and unable to go to the bathroom by herself can not be left home alone all day long, but may not qualify for the new community-based benefit.

Consumers Union supports including in the health plan a blueprint for future expansion of public long-term care benefits, including both expanded community based care and nursing home care. We recognize -- as should the Congress -- that these benefits will require a substantial new funding base, and we recommend that you consider increasing estate taxes (possibly by taxing capital gains at death), charging premiums for persons with incomes above a certain level, and increasing income taxes, and/or payroll taxes.

5. **Give the National Health Board the authority to regulate prescription drug prices that apply to all Americans, not just the Medicare- and Medicaid-eligible.**

The Administration's draft plan has several provisions that will help to keep prescription drug prices in check. The National Health Board, for example, can make public declarations regarding the reasonableness of launch prices for new drugs and can study and report on the reasonableness of drug prices. In addition, rebates of at least 17 percent of the average manufacturer price are required for drugs issued through Medicare and Medicaid. We believe the plan needs to go further. The United States is the only industrialized country that makes no effort to regulate drug prices, forcing U.S. consumers to pay higher prices to help pay for research that benefits citizens of other countries, who pay much lower prices. The Office of Technology Assessment recently reported that during the 1980's, pharmaceutical companies on average earned about 15 to 30 percent more profit than was needed to attract adequate investment capital. We strongly recommend that the National Health Board's responsibilities include the authority to regulate prescription drug prices.

6. **Universal health care must be a reality by 1997.**

Extending universality to all Americans must NOT be dependent on achieving cost savings and must not be phased-in with a vague timetable. Universality must be a reality by 1997. The plan must resist attempts to make the employer responsibility **voluntary** or

participation in health alliances **voluntary**. The level playing field for all employers and the end to cream-skimming by health insurers are critically needed elements in the plan.

7. Cost containment through limits on public and private spending must be kept.

Global budgets and premium caps to curb cost growth in both the public and private sector health spending are essential. The plan appropriately includes curbs on health care spending, and this backstop protection should not be sacrificed to give the failed "free market" cost containment efforts yet another chance to drive up health care costs. Also, Congress must guard against health care provider pressure to abandon the ban on balance billing and physician self-referral. These are two culprits that have contributed to today's high costs. In addition, Consumers Union will oppose granting antitrust exemptions for doctors, hospitals, and pharmaceutical companies. We oppose allowing, as the Act proposes, fee-for-service providers to collude in negotiating with alliances on the fee-for-service reimbursement schedule. This also will create upward, rather than downward, pressure on costs.

8. Keep most large employers in the system.

The Health Security Act would allow employers with more than 5000 workers to operate in a separate "corporate alliance" system, presumably with a tax of one percent or so to help pay for research that benefits everyone in the country. The "corporate alliance" system should NOT be expanded by reducing the minimum 5000 worker level, because to do so would undercut the goal of achieving a

universal system that treats all Americans the same and would contribute to a multi-tier system. The tax on corporate alliances should be preserved and set at a fair level: not only does it help pay some of the costs and subsidies of the system, but it helps decrease the incentive for large employers to opt-out of the system, reducing the "tiering" of health care. It is crucial that corporate alliances be required to offer the standard benefits package and be subject to the same set of rules that apply to health plans in regional alliances.

9. Protect the victims of medical malpractice.

It is vital that consumers most severely injured by doctor negligence be fairly compensated; there should NOT be any caps on malpractice awards for pain and suffering.

Contrary to the mythology that has evolved around the medical malpractice problem, malpractice premiums account for a very small portion of health care costs -- only about one percent. The Congressional Budget Office recently concluded that changes in the medical malpractice liability system would have a small impact on national health expenditures, and they therefore declined to "score" any savings. Goals of medical malpractice reform should be to identify and discipline doctors guilty of repeated medical malpractice, and to increase the ability of the system to fairly compensate malpractice victims.

10. Keep the benefits package comprehensive.

One of the strengths of the Clinton Administration health care reform package is the comprehensiveness of the benefits package,

including a range of benefits such as prescription drugs, some long-term care benefits, and mental health benefits. The benefits package must not be whittled away, or else the concept of universal protection and security will be compromised, and a burgeoning supplemental market will develop and help perpetuate a multi-tiered health care system.

Thank you very much for the opportunity to testify today. We look forward to working with your Subcommittee as this important debate continues.

Consumers Union
Publisher of Consumer Reports

SUMMARY

CLINTON HEALTH PROPOSAL: A CONSUMER PERSPECTIVE

Universality

The strongest element of the Clinton health proposal is that it extends health care protection to all Americans, moving the nation's consumers closer to health care security. It would end the tragic suffering faced by millions of people who are now denied adequate care because of pre-existing conditions or financial barriers. It offers consumers (for the most part) portability of benefits when they change jobs, and guarantees them health security even if they get laid off or get sick. Benefits are fairly comprehensive, though expansion of long-term care benefits is needed. The proposal should be modified to eliminate the multiple tiers of care by establishing the goal (within a reasonable time period) of integrating all of the different programs (Medicare, Medicaid, regional health alliances, etc.) into a uniform program for all Americans, with financing independent of employment status. Regulation of the supplemental market and private long-term care insurance market needs to be strengthened. The proposal should assure that states can adopt single-payer health care systems, providing the necessary funding.

Cost Containment

The best way to contain costs is to impose a global budget and to eliminate insurance companies. Eliminating insurance companies alone could save $67 billion per year. The proposal would curb health care costs through the use of a budget for the private sector and stringent control of the growth of Medicare and Medicaid budgets. Consumers Union has long supported global budgeting, and we endorse the intent of this portion of the plan, but recommend that the Administration and Congress carefully analyze the budget levels and modify them as necessary to assure parity -- equal sacrifice -- among all segments of the population. Steps must be taken to increase accountability of insurance companies participating as health plans to consumers -- not shareholders. We support the proposal's prohibition on physician self-referral (i.e., profiting from ordering services), a significant source of wasted health care dollars. Regulation of prescription drug prices for all consumers must be toughened. Antitrust guidelines (by the Department of Justice and Federal Trade Commission) should guarantee competition in the marketplace where it is beneficial to consumers.

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Fair Financing

Consumers Union believes that the best sources of revenue for health care reform are income taxes and payroll taxes (both sources where family contribution increases with income) and sin taxes (on tobacco, alcohol and firearms). The Administration proposal is funded primarily by premiums shared between employers and employees with an employer mandate. While Consumers Union believes that premium-based financing can be regressive, the inclusion of caps to protect low-wage employers and employees restricts the regressivity so as to make them an acceptable revenue source. However, caps (about 2 percent of income) on family/individual premium share are needed to further protect low-wage workers and allow for symmetry in the finance system. The Administration should consider replacing the premium system with a payroll tax because this would base financing on income, and would eliminate the many inequities that result when basing premiums on employment status (e.g., inequity between full-time and part-time workers; inequity between early retirees and later retirees).

Accountability to Consumers

We are not convinced that the creation of health alliances as consumer purchasing cooperatives assures the accountability of the health care system to American consumers. The major role played by insurance companies in the system will limit the system's accountability to consumers. Steps should be taken to increase insurance company accountability to consumers, and the proposal should provide funds to encourage states to adopt single-payer health care systems.

Freedom to Choose Providers

The proposal recognizes the strength of consumer demand for freedom to choose health care providers by requiring that each health alliance (with some exceptions) provide at least one fee-for-service health plan. However, the proposal should be amended to limit the premium differential charged by fee-for-service plans, and/or to subsidize the purchase of a fee-for-service plan by low-and moderate- income consumers in order to keep "freedom to choose provider" as an option for people of all income levels. During the transition period to a new health care system, consumers in a fee-for-service plan should be allowed to go to their current doctors, even if the doctor is part of another HMO or network. In the event that serious illness strikes or questions of quality arise, consumers enrolled in a low cost-sharing plan should be allowed to seek treatment outside of the plan (paying the higher cost-sharing amounts), until they can switch out of the plan during open enrollment.

Consumers Union
Publisher of Consumer Reports

THE CLINTON HEALTH CARE PLAN: A CONSUMER PERSPECTIVE

Like any proposal that contemplates dramatic change of a major industry, the President's health care proposal is not without serious flaws which we would like to modify. Consumers Union's comments and recommendations revolve around the five principles for health care reform that we embrace:

-- universal access to comprehensive benefits
-- cost containment
-- fair financing
-- accountability to consumers
-- freedom to choose providers.

Consumer Principle: Universal Access to Comprehensive Benefits

The strongest element of the proposal is that it extends universal health care protection to all Americans. It would end the tragic suffering faced by millions of people who are now denied adequate care because they are excluded from the health insurance market due to financial barriers or pre-existing conditions. The benefit package is comprehensive, and includes building blocks for long-term care. The proposal would put an end to insidious insurance company practices such as exclusions of pre-existing conditions, waiting periods, underwriting of high risks, and pricing practices that charge higher premiums for higher risks. Each eligible person would receive a health security card that would open the door to health benefits.

However, Consumers Union believes that the proposal perpetuates a **multi-tiered health care system**, with differentiation between populations such as the Medicare-eligible, the Medicaid-eligible, early retirees, corporate health alliance participants, regional health alliance participants, and military personnel. Different budget constraints apply to different segments of the population. The proposal should be strengthened by establishing a goal (within a timetable of five years) of working toward full integration of the entire population into a uniform system for everybody. Undocumented workers and their families should have full access to the uniform health care system since the plan specifically requires premiums to be paid for these workers. Instead of differentiation between groups, there should be benefit parity in all segments (Medicare, Medicaid, regional alliances, etc.). **We believe that health care reform will serve consumers better -- and will have broader public appeal -- if there is the perception and the reality that everybody is in this together.** Indeed, consumers want a

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system that provides uniform benefits regardless of age, income, health status, or employment status.

While the benefit package is comprehensive, there is one key area where expanded benefits should be included: **long-term care**. Even with a better-functioning private market, the private insurance market will not be able to solve the nation's long-term care problem. While the plan makes a good start by expanding community health benefits, eventually the benefits should be expanded to lower the activity of daily living (ADL) requirement for community based care and to allow for public financing of long-term nursing home care.

One of our health reform goals is to sever the **link between employment and health care coverage**. While the proposal does make coverage portable for most consumers, the employer and family/individual premiums are based on employment status, not income. Unlike an income-based finance structure (which can be achieved through a proportional payroll tax), the financing link to employment status (e.g., full-time, part-time, retiree, corporate alliance, etc.) creates inequities (e.g., between part-time vs. full-time workers, early retirees vs. senior workers). These inequities will make the plan unaffordable for many low-income consumers, forcing them to cut corners for basic necessities such as food and shelter in order to pay for their health care premium. The addition of an income cap would alleviate many of these problems just as the payroll cap will alleviate much of the burden on small low-wage businesses. (See the financing section below).

Regulations affecting the **supplementary insurance market** need improvement. First, there is no justification to allow the continued sale of low-value hospital indemnity insurance and dread disease insurance: these products should be banned outright. Consumer Reports has repeatedly concluded that these products are an essentially worthless purchase. Second, regulations and standardization should apply to the supplemental market for benefits, not only the supplemental market for cost-sharing. The supplemental market should consist of a limited number of (e.g., three to five) **standard** policies, and these policies should be subject to a loss ratio of 80 to 90 percent. Employers could offer these packages (premiums would be subject to taxation) or individuals could purchase these packages on their own **with no underwriting or pre-existing condition exclusions.** Benefits (packaged from a low to a high benefit package) could include: full dental coverage, full mental health coverage, expanded home care protection, full nursing home coverage, and unnecessary cosmetic surgery. Without these provisions, the supplemental market is likely to be characterized by confusion (as policies vary considerably) and low value products.

With regard to the comprehensive benefits package, it is important that the plan eliminate ambiguity as to whether health plans will be allowed to offer **benefits beyond the guaranteed benefit package**: health plans should be prohibited from including extra benefits in the basic package. Insurance companies have a long history of adding bells and whistles to policies that confuse consumers and enable them to charge unjustifiably higher premiums. If plans were allowed to add on extra benefits, the standardization that creates administrative simplicity and improves consumer comparison shopping would be compromised severely.

Whether the guaranteed benefit package is truly comprehensive depends in large part on how health plans under tight budget constraints interpret the coverage; consumers need protection against stingy interpretations that could result in denial of needed care (see the section below on accountability to consumers.)

Summary of Recommendations: Universal Access to Comprehensive Benefits

1. The proposal should establish a five-year goal of full integration of all populations (e.g., regional alliance enrollees, Medicare population, Medicaid population) into a uniform system for all, with identical benefits and choices.

2. The benefit package should be expanded (with an appropriate phase-in schedule) to include home care benefits with a less severe disability requirement and to include an expanded public program that phases in the funding.

3. Low-value policies no longer needed, such as hospital indemnity policies and dread disease policies, should be prohibited from being sold.

4. The supplemental insurance market for extra benefits (e.g., additional dental care, additional mental health benefits) should be subject to standardization (e.g., three to five standard policies) and should be subject to loss ratios of 80 to 90 percent. Supplementary policies should be community rated, and no underwriting or pre-existing condition exclusions should be allowed.

5. The proposal should be clarified to explicitly prohibit health plans from adding benefits to the comprehensive benefits package, unless the additional benefits are offered in a separately priced standard supplemental policy.

Consumer Principle: Cost Containment

Consumers Union is a strong supporter of global budgeting for health care expenses, because we view global budgets as the only sure way to rein in exploding health care costs. We welcome the fact that the Administration is making a very serious effort to curb the health cost spiral through a national health care budget. We endorse several elements of the plan that will curb spending: the national health care budget, constraining the growth of Medicare and Medicaid, banning self-referrals, establishment (by each regional alliance) of fee schedules for the fee-for-service component of health plans, and the prohibition of balance billing in excess

of fee schedules in the fee-for-service plan.

One of our concerns relates to the fact that the health care system will consist of many different segments. The differentiation leads to the need to treat different segments with different schedules and different sets of rules. We recognize that the plan builds in a .9% differential -- added allowed growth -- in the Medicare and Medicaid budgets. Growth in Medicare has been substantially greater than private health care growth -- by a differential of about 4 percent. We question whether the .9% differential will be adequate to correct the past inequities that have led Medicaid, in particular, to be a second-rate, lower quality portion of the nation's health care system. And we fear that if the .9 percent differential is too low, that Medicare will follow in the footsteps of Medicaid in delivering inferior care to senior and disabled citizens. Only by integrating the entire health system into a uniform system can there be assurance that everybody is treated fairly.

A second concern relates to the role of insurance companies -- which are accountable primarily to their shareholders -- in implementing the budget austerity called for by the plan. It is true that consumers can vote with their feet in the long term by joining a different health plan. But, when it comes to health care, short term considerations can have life and death implications. Switching health plans does little good if the reforms result in five or fewer competing health plans, with oligopolistic pricing and across-the-board low quality.

In your proposal, health plans whose premium bids exceed the target are assessed a penalty if an alliance's weighted average premium exceeds its premium target; this will lead to strong incentives for plans to keep downward pressure on their premium. This downward pressure is positive to the extent that health plans curb administrative costs, but we are concerned about undesirable effects if it leads insurance companies to deny legitimate claims, cut back too far in servicing their policy holders' needs, or over-expanding its review of provider's treatment decisions. We fear that hundreds of insurance companies, each with its own protocols, will interfere increasingly with doctors' clinical judgments. These are problems inherent in any system that retains a major role for private insurers. The best way to achieve true budget discipline is by establishing a single payer accountable solely to the American consumer -- this would assure that all consumers and providers are treated fairly and equitably.

Regulation of prescription drug prices needs to be strengthened. The responsibilities of the committee of the National Health Board should be stepped up to include broad authority to regulate prescription drug prices. First, the Board should conduct an analysis of prescription drug pricing, comparing prices of identical drugs in the U.S. with prices in other countries. The Board should review the excessive profits that drug companies have made on drugs that were discovered in part because of federally-financed research. Voluntary cost containment -- that limits growth of already grossly excessive drug prices -- is insufficient. In many cases, price rollbacks would be appropriate. The concept of the rebate (equal to at least 15 percent of average manufacturer price) for certain drugs that applies to the Medicare and Medicaid drug benefit should be expanded to all covered prescription drugs. Cost savings should be achieved across the board, not just for drugs covered under Medicare or Medicaid.

The National Health Board should study ways to broaden the principle of **global budgeting** to include health costs that are not included in the initial budget: supplemental benefits, health components of workers compensation and automobile insurance, premiums for cost-sharing benefits, long-term care benefits that are outside the package, and any other health expenses.

We have grave doubts that competition in the health care marketplace in reality can serve the consumer interest. We also question whether the marketplace will operate competitively or whether the new collaboration between formerly competing providers and a more highly concentrated insurance market will serve to maintain or raise prices as a result of oligopolistic pricing practices. We strongly support the proposed **repeal of the McCarran-Ferguson antitrust exemption**. We urge the plan to carefully spell out that Department of Justice and Federal Trade Commission guidelines called for in the plan are intended to minimize protected activities and maximize competition in this marketplace.

Summary of Recommendations: Cost Containment

1. Set the goal of an integrated global budget within a time period of five years that includes spending under an integrated benefit system and includes all national health care spending, to enable the system to treat all segments of the population fairly regardless of the cause or timing of the injury or illness.

2. Treatment protocols should be developed and generated by doctors and hospitals through a centralized system, not by utilization review companies that are accountable individually to hundreds of insurance companies. Increased use of outcomes research should be used to develop uniform treatment protocols.

3. The National Health Board should have broad authority to regulate drug prices, including price rollbacks and manufacturer rebates that would apply not only to Medicare and Medicaid prescription drugs, but to all covered prescription drugs.

4. The legislation should explicitly provide that the Department of Justice and Federal Trade Commission minimize safe harbor exemptions from the antitrust laws and maximize healthy competition in the health care marketplace.

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Consumer Principle: Fair Financing

Consumers Union believes that the best way to finance health care reform is through income-related payroll taxes, income taxes and excise taxes on tobacco, alcohol, and firearms. Because the proposed financing does not embrace this principle, it creates inequities and fails to generate sufficient revenue to achieve the level of benefits and subsidization we believe is needed. Adding a cap on the individual/family premium (as percent of income) would be an important step toward solving most of these problems.

The principle source of funding for the proposal is a premium-based employer mandate, with reasonable limits on the percent of payroll that employers must pay. The proposal includes subsidies for low-wage employers, significantly easing the burden on these businesses. Individuals and families are responsible for 20 percent of the premium plus any additional premiums resulting from plans whose costs exceed the average as well as premiums for supplemental policies.

One of our major concerns is the proposal's **lack of symmetry when it comes to capping employer AND employee premium contribution.** We believe that the employee's share of the premium (which is proposed to be 20 percent of the weighted average plus any amount of premium exceeding the average) should be capped at about 2 percent of income. Without such a cap, low wage workers who are not eligible for a subsidy (i.e., those with incomes above 250% of poverty) could face a very steep burden, especially if they want the freedom to choose their own doctor. A single mother who works full-time, for example, could be responsible for a premium of $900 on a $2500 policy, when the weighted average premium is $2000 and the employer contribution is $1600, 4.5% of a $20,000 income, an unreasonable burden for a low-income family. She would pay coinsurance and deductibles on top of the premium costs.

Under the proposal, **part-time workers** are responsible for a share larger than 20 percent of the weighted average premium because the employer share is prorated. A 15-hour-a-week low-wage worker will be liable for 60 percent of the premium (with 40 percent paid by the employer). It is not clear to us whether this must be paid even if the part-time worker's spouse is employed. If so, this would put a very steep burden on the family. In any case, part-time workers' premium payments should be capped as a percent of income, just as others' would be.

The proposal includes a **windfall for early retirees and their employers**: a subsidy (from the rest of the system's participants) for people who retire between ages 55 and 65. While we recognize that this segment of the population is in need of access to health insurance at affordable prices, we do not believe this substantial redirection of health care dollars is advisable. This problem points once again to the preferred way to finance health care -- through income-related taxes. It does not make sense to require low-wage workers to face premium costs of 5 percent or more of their income (on top of their employer's contribution) while early retirees, some of whom have substantial income, are responsible ONLY for the family/individual

premium portion. We need a system where everyone is treated the same, not a patchwork system that results in inequities.

We believe that it is appropriate to ask the **Medicare-eligible population** to help pay the cost of new prescription drug and long-term care benefits, through an increase in the Part B premium to cover 25 percent of the new benefit cost. Without this type of provision, seniors for the most part would receive a new benefit without having the opportunity to pay for it during their working years. However, the higher premium would represent a burden on lower-income seniors. We recommend that lower-income seniors (up to about 150 percent of poverty) be exempt from the premium increase, paying for this adjustment by increasing the proportion of the drug cost that would be paid by other seniors to perhaps 35 or 40 percent.

Summary of Recommendations: Fair Financing

1. Replace the mandated employer premiums with an income-related payroll tax, excluding the first $10,000 of income, eliminating inequities among two-worker/one-worker families, part-time employees, and early retirees.

2. Cap the family and individual premium payments (for the average cost policy) at 2 percent of income. (Allow this to be exceeded if the employee buys a higher-than-average-cost policy).

3. Ease the burden on low-wage workers by requiring employers to pay the individual/family share (20%) of the premium for employees with incomes up to 250% of poverty. (Employer contributions would still be subject to the overall caps).

4. To pay for the additional subsidies, for additional benefits such as long-term care, and for creation of parity between different programs (Medicare/Medicaid/regional alliances), impose an income surtax, a tax on new hospital revenues that are created by reduced spending for uncompensated care, and a tax on corporate alliances.

5. Exempt the lowest-income senior citizens (up to about 150 percent of poverty) from the increase in the Part B Medicare premium, increasing the amount paid by other seniors to cover 35 to 40 percent of the new prescription drug benefit. (The goal would be to have total new premiums pay for 25 percent of the new benefit).

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Consumer Principle: Accountability to Consumers

In theory, the creation of health alliances as consumer purchasing cooperatives increases the accountability of the health care system to American consumers. The make-up of health alliance boards, with membership balanced between consumers and employers, not providers and insurers, is an important component of this accountability.

Our biggest concern in this area is the **major role that will be played by insurance companies** in implementing the new system. How, for example, will insurance companies cut costs in order to live within the budget constraints? Unfortunately, we cannot assume that insurance companies will always cut the "right" costs -- administrative waste, unnecessary care, and red tape. They will have a strong incentive to cut needed health care services as well. We also fear that they will each use their own individual treatment protocols, their own utilization review companies, and will interfere with doctors' treatment decisions.

The health care system needs more outcomes research and needs protocol for weeding out the $130 billion wasted each year on unnecessary care. But we question whether this can be done fairly and efficiently through hundreds or thousands of individual for-profit entities, rather than through a single entity accountable only to the public.

The National Health Board is charged with awesome responsibilities that will determine the quality of the health care system and its ability to constrain costs. It is critical that the selection criteria for members assure the appointment of the most qualified people who are committed to serving the interests of consumers.

The proposal allows states to establish a **single-payer health care** system, but includes a provision that seems to discourage states from doing so. It would require that states appropriate revenue from "sources other than those established by this Act" to pay for the program. Does this provision preclude a state from imposing a payroll tax, one of the provisions of most single-payer legislation? In light of the ability of a single-payer system to achieve the principles of universality, cost containment, accountability to consumers, freedom to choose providers, and fair financing, the federal government should provide the necessary funding to states to **encourage** them to adopt a single payer health care system.

We are pleased that the **medical malpractice proposals** in the plan would not cap damages received by the victims of medical negligence. Additionally, we applaud the provision allowing consumers to obtain information concerning doctors who commit repeated acts of malpractice. Providing this important information will help consumers make a **meaningful** choice of doctors. We are concerned that the award will be reduced by any amount obtained from collateral sources after a finding of malpractice. While we do not believe in double recovery, we do think that the wrongdoer should pay, not be subsidized by the victim's insurance policies. Malpractice premiums should be experience-rated; caps on lawyers' fees should apply to lawyers on both sides; and to avoid conflict-of-interests, alternate dispute

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resolution mechanisms should be conducted within the health alliance, not within individual health plans.

Summary Recommendations: Accountability to Consumers

1. Make the state single-payer option a real alternative by encouraging states to exercise this option through federal assistance, providing the necessary funding.

2. Increase accountability of insurance companies/health plans to consumers by placing requirements on insurance company/health plan boards of directors. At least half of the board members should represent consumer interests and have no financial stake in the profitability of the company. Insurance company executives' salaries (i.e. total compensation) should be open to public review and scrutiny.

3. In appointing members to the National Health Board, both the President and the Congress should carefully review each candidate's commitment to the quality of the health care system (while allowing for a willingness to improve the system).

4. Medical malpractice premiums for providers should be experience-rated, so that the vast number of doctors who provide excellent care are rewarded by lower premiums and the few doctors who provide substandard care are penalized by higher premiums.

5. Caps on lawyer fees that are imposed on lawyers representing medical malpractice victims should also be imposed on defense lawyers.

6. Practice guidelines should not be used to shield doctors who commit malpractice.

7. The Alternative Dispute Resolution System should function at the Alliance level, not at the health plan level because of the conflict of interest that a health plan has in any malpractice situation.

Consumer Principle: Freedom to Choose Providers

Freedom to choose their own health care provider is one of the most highly valued features that consumers seek in their health care system. Consumers want to be able to continue long-standing relationships with their family doctors, specialists, pediatricians, and other health care providers. Often, one family will have an array of doctors, making it impossible to follow them all to one HMO. Consumers want to be assured that if serious illness strikes, they will have access to the highest-quality specialist and specialized treatment centers.

The proposal recognizes the strength of consumer sentiment on this important attribute by requiring that each health alliance includes at least one **fee-for-service** plan. (States can ask the National Health Board for a waiver from this requirement in very limited circumstances). In most regional alliances, consumers will be able to choose from a low cost-sharing plan (presumably in an HMO with virtually no ability to go outside the HMO for non-emergency medical care), a high cost-sharing plan (apparently with freedom to go to a fee-for-service doctor) and a combination plan, with most care delivered within an HMO or network, but freedom to go outside of the network for medical care with higher cost-sharing requirements.

While this proposal does indeed provide most consumers with some flexibility, we fear that many low- and middle- income consumers will not be able to afford to pay considerably higher premiums that could be associated with fee-for-service plans. Without some constraint on premium differentials between fee-for-service and HMO-types of plans, freedom of choice of provider could be a luxury only the rich can afford. Health alliances should take steps to assure that competition among health plans is based primarily on quality, not price. In negotiating for a fee-for-service health plan, health alliances should address this concern and consider ways to make this option available to all, by limiting premium differentials to about 10 percent, by requiring employers to pay the individual/family 20-percent-premium-share for employees with incomes up to 250 percent of poverty (thus making them better able to afford the fee-for-service option if they want it), and other options. Again, the plan should facilitate the creation of single payer health care systems, which preserve the freedom of provider for all consumers, through start-up grants.

Under this proposal, consumers face considerable uncertainty about whether their **current doctors** will be available to them -- even if the consumer chooses a fee-for-service option. It is impossible for anyone to predict which of their doctors will join which HMO and whether all of the doctors will be available in the same HMO. In order to allay concerns for this transition to a new system, we recommend that consumers enrolled in a fee-for-service plan should be allowed to continue to see their present doctors, even if any of these doctors sign up to work in an HMO or physician network that is not a part of the consumer's fee-for-service plan, during a transition period to be determined by the regional alliance.

Another concern is that a consumer will sign up for the low-cost-sharing (HMO) option in the beginning of the year (when healthy), and will regret this **inflexibility if a serious illness strikes**. In the long-run (annual open enrollment), the consumer will be able to switch to a more flexible health plan. We believe that in the event of serious new illness or dissatisfaction with treatment provided, some flexibility to go outside of a low cost-sharing health plan should be allowed. Under this proposal, plans should be allowed to recapture increased costs (or lost revenues from higher "combination" cost-sharing) through retroactive premium adjustments from individuals and families who exercise this option.

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Summary Recommendations: Freedom to Choose Providers

1. During the transition period, consumers who enroll in a fee-for-service plan should be allowed to see their current physicians, even if these doctors are enrolled in an HMO or other provider network outside of the fee-for-service plan.

2. Health alliances should assure that a fee-for-service option is accessible to all consumers, e.g., by imposing a 10 percent premium differential (over the average premium plan) for a fee-for-service plan, or by requiring employers to pay the family/individual share of premium for employees at less than 250 percent of poverty.

3. In the event that serious illness strikes or questions of quality arise, consumers enrolled in a low-cost sharing plan should be allowed to seek treatment outside of the plan (paying the higher cost-sharing amounts), until they can switch out of the plan during open enrollment.

4. The National Health Board should facilitate the state adoption of a single payer system through provision of necessary funding.

Mr. REED. Ms. Davis.

Ms. DAVIS. Good morning. I am Michele Davis, an economist with Citizens for a Sound Economy, a 250,000-member consumer advocacy group offering market-based solutions to public policy problems. I am glad to be here today to offer comments on the effect of the Clinton health care plan on consumers.

The current health care system clearly needs reform, but the Clinton proposal is not the answer. The Clinton health care proposal includes many drastic changes to the current health care system that endanger the quality and availability of health care choices for American consumers. The mandated benefits package limits consumer choice, forcing everyone to pay for benefits they may not want or need. Employers and employees will be prohibited from negotiating over health insurance benefits; for example, trading broader benefits for increased cash wages and contract bargaining. Instead that decision would lie in the hands of the government.

Second, the proposed regional Health Alliances also limit consumer choice. Most consumers would have only one place to go to buy health insurance. If they didn't like the options available there, they would have nowhere else to turn.

But the single largest threat to both quality care and consumer choice is the cap on health insurance premiums. In recent years, health insurance premiums have increased at double, and even triple, the rate of inflation. Both fee-for-service plans, HMOs, and anything in between, experienced large annual cost increases because none of these systems give consumers any significant incentives to control costs.

The lack of consumer cost consciousness is a major source of the excessively high health care spending our system experiences today, and spending increases in turn leads to bloated health insurance premiums.

At the same time, government health care programs, especially medicare and medicaid, shift costs onto privately insured patients, contributing to private health care cost inflation. The Clinton proposal does nothing to return consumer cost consciousness to the health care market, the public or private aspects of it. Instead the proposal would artificially control health care spending by mandating a cap on annual health insurance premium increases.

Despite administration assurances to the contrary, these price controls will ration the health care available to American consumers whether they are enrolled in a regional Health Alliance or a corporate alliance.

History and economics both reveal that when the government artificially restrains prices producers restrict supply and reduce the quality of goods available. In short, consumers face rationing.

In the 1970s, price controls on gasoline led to lines at the pumps, and rent controls have reduced the quality and availability of housing in cities like New York City. Consumers would face the same phenomena of lower quality and reduced access to services under the Clinton health plan. The proposed National Health Board would determine an allowed average premium for each health alliance. All health plans would be squeezed between growing consumer demand on the one hand and price caps on the other.

Because the Clinton proposal explicitly allows Health Alliances to refuse to sell plans that exceed the average premium by 20 percent or more, an insurer may find itself unable to raise revenue to meet rising costs. The only alternative then would be to ration care to patients.

In fact, the administration's scheme explicitly gives physicians, hospitals and other health care providers clear financial incentives to limit services to patients. These incentives lie in the powers granted to regional Health Alliances to enforce mandated premium caps.

In the event that an average health insurance premium in any region exceeds the mandated cap, the regional Health Alliance could tax all health plans charging above average premiums and also tax their participating physicians. Doctors enrolled in these health plans can only avoid this tax by limiting patient access to care.

The National Health Board also has broad enforcement powers to assure that corporate alliances meet their premium targets. If the average premium in a corporate alliance exceeds the allowed cap in two out of any three years, the corporate alliance could be disbanded. To keep premiums below this mandated cap, alliances and their participating health plans will also be forced to ration care.

The administration contends that this result is unlikely because the premium caps are generous and so represent only a fallback position. The evidence, however, contradicts this claim.

After 1998, the allowed average premium would increase only at the rate of general inflation. Socialized health care systems around the world that explicitly ration care, like those in Canada and England, all experience annual cost increases well above the rate of general inflation.

Many health plans today already limit consumer access to care. Some types of HMOs pay providers a flat fee per patient per year and whatever the—enrolled patients have to see a gatekeeper physician before they can see any other doctor, and the health plan will only pay specialists if the gatekeeper gives approval. These are the types of systems all consumers will be forced into under the Clinton health care plan.

In addition to restricting access to current medical services, the price controls in the plan will also limit development of future medical technologies. It is impossible to measure the costs, both human and economic, that lost medical research could inflict on American consumers.

The current health care system clearly needs reform, but Congress can expand access to care and control costs without creating the enormous new entitlement program proposed by the administration. Simply allowing people to group together to buy health insurance and making health insurance affordable would address much of the current problem. Malpractice reform and changes in the Tax Code would further empower consumers to control their own health care spending.

Health care reforms that put consumers, not the government, in control can get health care costs under control without creating a new bureaucracy or arbitrarily rationing care.

Thank you.

Mr. REED. Thank you very much, Ms. Davis.

[The prepared statement of Ms. Davis follows:]

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TESTIMONY OF MICHELE DAVIS
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CITIZENS FOR A SOUND ECONOMY
before the
LABOR-MANAGEMENT RELATIONS SUBCOMMITTEE
of the
HOUSE EDUCATION AND LABOR COMMITTEE

November 9, 1993

Good morning Chairman Williams and members of the subcommittee. My name is Michele Davis, and I am an economist with Citizens for a Sound Economy (CSE), a 250,000 member consumer advocacy group offering market-based solutions to public policy problems. I am glad to be here today to offer comments on the effects of the Clinton health care plan on consumers.

The Clinton proposal includes many drastic changes to the current health care system that endanger the quality and availability of health care choices for American consumers. The mandated benefits package limits consumer choice, forcing everyone to pay for benefits they may not want or need. Employers and employees would be prohibited from negotiating over health insurance benefits--trading broader benefits for increased cash wages in contract bargaining. Instead, that decision would lie in the hands of the government.

Second, the proposed regional health alliances also limit consumer choice. Most consumers would have only one place to go to buy health insurance. The Regional Health Alliances and Corporate Alliances would have monopoly powers similar to the Postal Service today. If consumers didn't like the options available there, they would have nowhere else to turn.

But the single largest threat to both quality care and consumer choice is the cap on health insurance premiums.

In recent years, health insurance premiums have increased at double and even triple the rate of inflation. Both fee-for-service plans and Health Maintenance Organizations (HMOs) experience large annual cost increases because neither system gives consumers any significant incentive to control costs. In HMOs, consumers pay small fees, if anything at all, for medical care. And in fee-for-service plans, once consumers have met their deductibles, they pay only 20 percent of their health care bills. Doctors might as well hold an 80 percent off sale. This lack of consumer cost-consciousness is a major source of

excessively high health care spending. Spending increases, in turn, lead to bloated health insurance premiums.

At the same time, the government health care programs, especially Medicare and Medicaid, shift costs onto privately insured patients. The federal and state governments reimburse doctors and hospitals less than the full cost of many medical services, forcing providers to raise their prices in order to cover these losses. Over time, the difference between Medicare and Medicaid payment rates and provider costs has expanded, contributing to private health care cost inflation. The Clinton health care plan includes further reductions in future Medicare reimbursements to hospitals, which will only exacerbate the cost-shifting problem. Without real reforms in these government-run health care programs, any reform of the private sector is unlikely to succeed.

The Clinton proposal does nothing to return consumer cost-consciousness to the health care market. Instead, the Clinton proposal would artificially control health care spending by mandating a cap on annual health insurance premium increases. Despite Administration assurances to the contrary, these price controls will ration the health care available to American consumers, whether they purchase insurance from a Regional Health Alliance or a Corporate Alliance.

History and economics both reveal that when the government artificially restrains prices, producers restrict supply and reduce the quality of goods available. In short, consumers face rationing. In the 1970s, price controls on gasoline led to lines at the pumps. And rent controls have reduced the quality and availability of housing in cities like New York City.

Consumers would face the same phenomena of lower quality and reduced access to services under the Clinton health care plan. The proposed National Health Board would determine an allowed average premium for each Regional Alliance and each Corporate Alliance. While large employers could avoid the bureaucracy of the Regional Alliance by setting up their own alliance, they would still be subject to limits on the increase in the average health plan premium.

All health plans would be squeezed between growing consumer demand on the one hand and price caps on the other. Because the Clinton proposal explicitly allows health alliances to refuse to sell plans that exceed the average premium by 20 percent or more, an insurer may find itself unable to raise revenue to meet rising costs. The only alternative, then, would be to ration care to patients.

In fact, the Administration's scheme explicitly gives physicians, hospitals and other health care providers clear

financial incentives to limit services to patients. These incentives lie in the powers granted to regional alliances to enforce the mandated premium caps. In the event that the average health insurance premium in any region exceeds its mandated cap, the Regional Health Alliance could tax all health plans that charge above average premiums, and also tax their participating physicians. Doctors enrolled in expensive health plans can only avoid this tax by limiting patient access to care.

The National Health Board has broad enforcement powers to assure that Corporate Alliances also meet their premium targets. If the average premium in a Corporate Alliance exceeds the allowed cap in two out of three years, the Corporate Alliance can be disbanded. Any large employer that wants to continue providing coverage for its employees will bear this threat in mind and negotiate lower premiums with participating health plans. To keep premiums low, these health plans too will be forced to ration care.

The Administration contends that this result is unlikely because the premium caps are "generous" and so represent only a fallback position. The evidence, however, contradicts this claim. After 1998 the allowed average premium would increase only at the rate of general inflation. Socialized health care systems that explicitly ration care--such as those in Canada, England and Germany--all experience annual cost increases well above the rate of general inflation.

Many health plans today already limit consumers access to care. "Capitated physician" HMOs already provide physicians with incentives to limit patient services. HMOs pay their gatekeeper physicians a set fee per patient per year. Every enrolled patient must see the gatekeeper before seeing any other doctor, and the health plan will only pay specialists if the gatekeeper has given approval.

The gatekeeper must keep a strict budget. The annual fee from each patient must cover all that patient's medical bills for the year. At the end of the year, whatever is left of the annual fee is divided between the doctor and the HMO. The incentives are clear--the fewer services a gatekeeper physician allows, the larger his income. On the other hand, if a doctor spends more on a patient than the annual fee, the difference comes out of the doctor's pocket.

These HMOs already ration care. The important point, however, is that consumers today can choose whether or not to enroll in such an plan, and even after enrolling can go outside the system to purchase extra services. Under the Clinton proposal, consumers would have no choice--all health plans would face severe budget constraints--forcing them to ration care.

In addition to restricting consumer access to current medical services, the price controls in the Clinton plan would also limit the development of future medical technologies. Health plans already stretching their resources to cover a mandated benefits package would be reluctant to extend coverage to any new technology, no matter its merits. In such an environment, medical and pharmaceutical research would grind to a halt, drastically limiting future health care choices. It is impossible to measure the costs--both human and economic--that lost medical research could inflict on American consumers.

Over all, the Clinton health care plan will force consumers to pay more for less care. Consumers will bear higher taxes and the cost of employer mandates and then will suffer under rationed health care as the federal government imposes drastic health insurance premium caps.

The current health care system clearly needs reform. But Congress can expand access to care and control costs without creating the enormous new entitlement program proposed by the Administration. Simply allowing people to group together to buy insurance and making health insurance portable by eliminating current tax biases would address much of the current problem. Malpractice reform and changes in the tax code would further empower consumers to control their own health care spending. Health care reforms that put consumers first can control health care costs without creating a new bureaucracy or arbitrarily rationing care.

Thank you.

Mr. REED. Mr. Pollack?

Mr. POLLACK. Mr. Chairman, thank you.

I want to focus my remarks on one of the issues that undoubtedly will be one of the more controversial questions that will come before you; namely, the employer mandate.

Clearly, the President has laid out the challenge for everyone in Congress with respect to security, and today insecurity really is the hallmark of our health care system. Each month more than two and a quarter million Americans who are insured lose health insurance.

Now, many of these people lose insurance for a temporary period of time, whether it is three months or five months or seven months. Some, however, lose it for a year or more. For each of them who lose insurance, they feel terribly insecure about the health care system and it places them in a very vulnerable position.

Over the course of a year, almost 60 million Americans, almost 1 out of 4 Americans, experience a lack or a loss of health insurance for some portion of the year, and that means that very significant numbers of Americans feel terribly insecure because they have felt the loss of health insurance.

Now, the President's plan builds on our current system. He requires that employers provide coverage for all of their employees, and I think there are significant advantages to this proposal and I hope that this committee will support that approach.

First, and perhaps very importantly, is the fact that this is perhaps the least disruptive way of achieving coverage for everyone. After all, our current health care system is an employer-based system where most people derive their insurance through the workplace. So, extending this would probably cause the least disruption with respect to the health care system.

Secondly, it would place employers on a fair competitive footing. Today, if one employer is competing with another, one is providing insurance coverage and the other is not, there is an artificial disadvantage to the employer that is fulfilling responsibilities to employees. This would place the various firms on an even playing field, and I think that is to be recommended.

Thirdly, one of the things, perhaps, that is least understood is that if one employer provides coverage for employees and the other one doesn't, the employer who does provide coverage, in fact, pays for the employees of the employer who does not provide coverage. For example, if Julie's hardware store has eight employees and Julie provides coverage for her employees, and Jim's hardware store similarly may have eight employees and Jim does not provide coverage for his employees, if Jim's employee goes from work this just say afternoon and gets into a car accident and goes to the emergency room, that employee will receive care and somebody is going to pay for it. And the person who is going to pay for it, in effect, is Julie. Because when Julie's employees go to the hospital, her employees are, in effect, going to get a hidden surcharge on the bill to make up for the loss of revenues for those people who are uninsured.

So, in effect, Julie is not only paying for her employees, and Jim is not therefore putting her at a competitive disadvantage, but she

is also subsidizing Jim's employees as well. This would come to an end if we had an employer mandate.

Now, I suggest to you that perhaps the most significant concern that the employer mandate raises is what its impact is going to be on small businesses, and I think that the administration has been very sensitive to the concerns of small businesses and that the package as a whole will be very advantageous to small business.

Number one, the administration provides discounts to small businesses that have difficulty paying for premiums, and these discounts will extend to employers with as many as 75 employees.

Secondly, the administration provides for pool purchasing which will provide two advantages: Number one, it will reduce the administrative cost that small businesses are bearing today; 40 cents out of the dollar in premiums today goes for administrative costs. By improving through economies of scale, administrative costs will be significantly reduced, and it will provide improved leveraging power vis-a-vis the insurance companies.

I suggest to you that an employer mandate not only will effectively extend coverage for everybody, but it is a fair way to achieve it. It will be least disruptive for the system, and I believe as we go through this the alternatives either don't get the job done or are significantly disruptive.

Thank you.

Mr. REED. Thank you very much, Mr. Pollack.

[The prepared statement of Mr. Pollack follows:]

Ronald F. Pollack
Executive Director

Chairman Williams and Members of the subcommittee:

Thank you so much for inviting me to testify today about the impact of the Clinton health plan on American Families. Families USA is enthusiastically supporting the Health Security Act of 1993.

Our current health system has deprived American families of the peace of mind of knowing that they will always be able to take care of their families' health care needs. This Families USA special report looks at the wide variety of problems American families are experiencing with our current health care system and at how President Clinton's Health Security Act of 1993 will address these problems. As the following analysis shows, the Clinton health reforms, if enacted, will provide the security and peace of mind that American families so profoundly lack today.

PEOPLE WHO WILL LOSE THEIR INSURANCE

Jerry and Donna Weldon live in Fenton, Missouri with their two young children. Jerry is a plumber and the family is covered through Jerry's union. Every three months, Jerry must work a certain number of hours to qualify for health insurance coverage. Lately, work has been slow, so Jerry is working fewer hours and the number of work hours required by the union for health insurance will be increasing. The Weldon's eight-year old son has leukemia and he is scheduled for a bone marrow transplant this fall. After this procedure, he will need ongoing medical care and prescription drugs. The Weldons are worried that they will lose their insurance in the future because of Jerry's lack of work and the increasing number of required work hours for coverage.

Over two million Americans lose their health insurance each month. Over 57 million Americans will be without insurance for some time in 1993.[1] Most of these people will lack insurance for less than five months, yet a significant portion will lack insurance for six months or more.[2] During this time, families are at grave financial risk if they become sick or injured.

As of 1998, under the Health Security Act, Americans can no longer lose their health insurance. A health security card will guarantee all Americans nationally-defined, comprehensive health benefits that continue without interruption regardless of any changes in health, employment or economic status. Workers and their families will receive insurance coverage through their employment. Self-employed or unemployed people and their families will purchase coverage directly. Self-employed families' insurance premiums will be fully tax deductible, instead of only 25 percent deductible as they are now. Businesses and families having the greatest difficulty paying for premiums will receive discounts to make their premiums affordable.

Families will choose from a variety of health plans offered by regional health alliances where they live. Employees of firms with more than 5,000 employees may choose from at least three plans offered by their firm. Americans over age 65 will continue to enroll in the Medicare program, as they do now, and will also have the option of choosing managed care plans.

Under the Health Security Act, the Weldons would always have the same comprehensive insurance, regardless of how much work Jerry can get.

INADEQUATE INSURANCE

Susan and David Mast live in Wheaton, Maryland, with their two young children on an income of $20,000. David Mast is a self-employed contractor and purchased health insurance coverage on his own. He paid $4,000 for his family's health insurance in 1992, but couldn't afford the extra $4,000 a year maternity coverage would have cost. Even then, the coverage wouldn't have been effective for one year. Their youngest child was born in February 1992. Susan Mast worked two jobs as a proofreader and typesetter, and took in babysitting and accounting work, to pay off the $3,300 bill from that birth.

Millions of Americans currently have inadequate insurance that can leave them with thousands of dollars in medical bills. Such inadequate coverage is most common for families who buy non-group coverage and can only afford or qualify for very limited coverage with high deductibles, high copayments or limitations in benefits. Some families can only purchase policies with low lifetime payment levels, thereby leaving them vulnerable to high debts if a serious illness strikes.

Families USA estimates that 18 million Americans who have insurance are currently spending ten percent or more of their pretax income on out-of-pocket health expenses, *excluding* expenses for nursing home care, health insurance premiums, Medicare payroll taxes, federal, state and local taxes, and wages lost because of their employers' costs for health insurance.[3] Economists generally consider individuals to be underinsured if they are *at risk of* spending ten percent or more of their income on out-of-pocket health costs.[4]

The Health Security Act will guarantee all Americans comprehensive health coverage. The comprehensive benefit package guarantees access to a full range of services. The benefits include a variety of preventive services available at no
cost. In addition, prescription drug, dental and mental health services are more generous than many plans today. No individual will have to spend more than $1,500 annually for covered services and no family will have to spend more than $3,000 annually.

The guaranteed national benefits have no lifetime limitations on coverage and include: hospital services; emergency services; services of physicians and other health professionals; a variety of preventive services; mental health and substance abuse services; family planning services; pregnancy-related services; hospice; home health care; extended-care services; ambulance services; outpatient laboratory and diagnostic services; outpatient prescription drugs and biologicals; outpatient rehabilitation services; durable medical equipment, prosthetic and orthotic devices; vision and hearing care; preventive dental services for children; and health education classes.

Under the Health Security Act, the Mast family would always have comprehensive health benefits, including full maternity coverage.

HIGH PRESCRIPTION DRUG COSTS

Iona O'Neill is an 83 year old resident of Spring Hill, Florida. Iona's income from Social Security is less than $700 per month. She has no insurance covering prescription drug costs. Iona suffered bladder cancer and now spends $300 per month on medicine. Her income is too high, however, to qualify for any public assistance with prescription drug costs.

Paying for prescription drugs is an onerous burden for many Americans. An estimated 72 million Americans currently lack health insurance for prescription drugs.[5] Medicare does not cover outpatient prescription drug costs. Elderly persons take more prescriptions, on average, than younger people and have higher drug costs, but less than half (49%) of all elderly Americans have prescription drug coverage.[6] As a result, elderly persons pay almost two-thirds (64%) of their prescription drug costs out of pocket.[7]

Prescription drug costs have increased much faster than inflation. From 1985 to 1991, inflation was 21 percent. Yet the cost of prescription drugs increased 66 percent over the same period and the cost of the 20 brand-name drugs most commonly purchased increased 79 percent.[8] Americans, therefore, not only pay significant amounts out of pocket for prescription drugs, but these costs are consuming a larger and larger portion of their incomes.

As of January 1, 1996, Medicare beneficiaries will no longer see prescription drug costs eating up their incomes if the Health Security Act is enacted. They will be eligible for a new outpatient prescription drug benefit. After an annual deductible of $250 per person, Medicare beneficiaries will pay only 20 percent of prescription drug costs up to an annual maximum of $1,000. The benefit will be part of Medicare Part B. Ninety-seven percent of Medicare beneficiaries elect Part B coverage and pay Part B premiums that cover 25 percent of Part B costs. After 1996, the deductible and out-of-pocket maximum will increase only for inflation.

All Americans under age 65 also will have coverage for prescription drug costs as of 1998. After a maximum annual deductible of $250 for individuals or $400 for families, individuals will pay either $5 per prescription or 20 percent, depending on the health plan. If an individual's health costs exceed $1,500 or a family's costs exceed $3,000 in a year, they will no longer have to make any additional payments for prescription drugs.

Under the Health Security Act, Iona O'Neill would pay only the first $250 each year of her prescription drug costs and 20 percent of her prescription drug costs up to $1,000. If she spent $1,000 on prescription drugs in a year, Medicare would cover the remainder of her prescription drug costs.

EARLY RETIREES LOSING THEIR HEALTH BENEFITS

Kazimer "Casey" Patelski and his wife Bonnie live in Costa Mesa, California. Casey was a design engineer for McDonnell Douglas for 28 years. He helped design various aircraft, missiles, satellites and the Skylab Space Station. Casey, who suffered from polio as a young man, turned down numerous job offers from other companies over the years because of the generous retirement benefits, including health insurance, promised by McDonnell Douglas. When Casey retired at age 63, he was assured that he and Bonnie would have health insurance coverage for the rest of their lives. A year later McDonnell Douglas announced that it was eliminating health insurance benefits for all retirees. Current retirees, like the Patelskis, were allowed to purchase health insurance coverage with their pension funds.

Companies across the country are reducing their work forces by encouraging employees to take early retirement. Former employers are the primary source of health insurance for retirees who are not yet eligible for Medicare. One-third (32%) of the retirees covered by their former employers are under age 65.[9] In light of skyrocketing health care costs and new accounting rules requiring employers to report this liability, companies are cutting health benefits for current and future retirees.

In the last few months, both McDonnell Douglas and Unisys corporations eliminated all health benefits to their current retirees, leaving some 45,000 retirees and their families without health insurance protection.[10] These corporations are not alone. A recent major survey of larger corporations found that 12 percent of companies responding have eliminated or plan to eliminate all retiree health benefits. Another 56 percent have reduced or plan to reduce health benefits covered.[11]

The Health Security Act would provide early retirees and their families with guaranteed health coverage. Under the Act, the federal government would pay 80 percent of premiums for retirees between the ages of 55 and 65. For retirees whose previous employers currently pay retiree health costs, their employers would now be required to pay the retirees' share of premiums (20 percent).

Under this Act, the federal government would pay 80 percent of the Patelskis' health insurance premiums until Mr. Patelski was eligible for Medicare.

JOB LOCK

When Melanie Wood was pregnant with her third child, she intended to leave her job with the Harris County juvenile probation department to become a full-time mother. At the time, the family had health insurance coverage through Melanie's job. Jordan, now ten, was born with Sturge-Weber syndrome, a congenital neurological disorder that left him blind in his left eye and caused a large port-wine stain over most of his body that requires laser treatments. Jordan also has hydrocephalitis and needs a shut to drain excess fluid from his brain. Melanie started calling insurance companies from her hospital bed immediately after Jordan's birth and she found that Jordan was uninsurable. Since her husband, Randy, is self-employed, Melanie was

forced to return to work in order to keep health insurance protection for her family. Melanie wants to be at home with her children, but if she leaves her job, her family will no longer qualify for insurance.

American families with a member who has a chronic health condition can easily find themselves in the position of being unable to change jobs because the family is dependent on the health insurance obtained through one family member's job. One in five (19%) workers report that they or a family member are locked in their jobs because new work offers limited or no health insurance.[12] The worker, or the worker's spouse or children, may have existing health problems that will prevent them from being able to get new insurance after a job switch. Small businesses and individuals experience great difficulty obtaining comprehensive health coverage for people with preexisting health conditions. A worker seeking to change jobs may find a potential job that does not offer health benefits at all.

The Health Security Act, immediately upon enactment, will prohibit insurers from excluding preexisting conditions for individuals and their families who were insured within the previous 90-day period. For individuals and their families who were not previously insured, insurers can limit coverage for preexisting conditions for no more than six months. The Act also immediately requires insurers to accept all newly-hired, full-time employees and their families added to groups currently insured. By 1998, the Act prohibits exclusions for preexisting conditions under any circumstances.

As of 1998, under the Health Security Act all employers will contribute 80 percent of average premium costs for health insurance for workers and their families, or more if they choose. Workers will no longer have to choose between jobs that offer health benefits and those that do not.

Under the Health Security Act, if Melanie Wood became a full-time mother, the Wood family would be able to get health insurance through the regional health alliance for the same premium as everyone else in the region. The family would be able to fully deduct the cost of the premium since Randy Wood is self-employed.

SMALL BUSINESS OWNERS AND THEIR FAMILIES

Ann and Hubert Maddux live in Corpus Christi, Texas with their four-year-old daughter and infant son. Hubert runs a tackle shop makes approximately $25,000 a year. As a small business owner the best insurance Hubert could get for himself and his family was through his alma mater in 1986. At that time his premiums were $1,000 a year. After their daughter was born with Downs Syndrome and serious heart defects, the Maddux family's premiums increased to $17,000 annually. Recently they were able to reduce the premium to $14,400, but they have to pay a $1,000 deductible per person and half of the first $2,500 in covered expenses per person. Both children need prescription drugs which the family's insurance does not cover. Medicine for the children costs the family between $100 and $200 a month.

Small business owners, employees and their families encounter great difficulties obtaining affordable health insurance. Small groups generally must pay ten to 40 percent more for health

insurance than large groups. Business owners experiencing problems like those of the Maddux family often face much higher premiums.[13] Small groups are at a disadvantage because they lack the bargaining power that enables larger groups to negotiate reduced provider payments and premium rates.

Likewise, small groups bear much of the burden of paying for uncompensated care to the uninsured, since they do not have the clout to negotiate reduced provider and premium rates. Small groups pay higher administrative costs for insurance than larger groups. Administrative costs can account for up to 40 percent of premium costs for very small groups, as compared with six percent of premium costs for very large groups.[14]

Small group premiums are often experience-rated, which means that they are based on the actual claims experience of the group. Since small groups cannot spread the claims costs across many persons, experience-rated premiums are often high and can escalate rapidly if one member of the group has a serious health problem.[15] According to a survey by the National Federation of Independent Business, the high cost of health insurance is the most pressing problem confronting small business.[16]

Those who would purchase health insurance as individuals or as part of a small business group face another formidable barrier to health coverage—medical underwriting practices. Medical underwriting is the process by which an insurer evaluates the health history and the potential for poor health status, and high claims, for an individual or group. In addition, insurance companies often deny coverage to small employer groups based on the nature of the industry, such as agriculture, retail or construction, or offer them only limited coverage because of employees' health status or claims experience. Based on current underwriting practices, approximately 15 percent of all small businesses are ineligible for insurance or eligible only for restricted coverage.[17]

The Health Security Act will end the discrimination small groups and individuals have experienced in the insurance marketplace. Most Americans will obtain their insurance through consumer-controlled regional health alliances where they live.
This pooling of individuals and businesses will result in lower premiums for those who previously purchased insurance as small businesses or individuals. By purchasing insurance through regional pools, small businesses and individuals will benefit from the negotiating power of large groups with insurance companies.

Under the Act, small businesses and individuals will no longer see their premiums skyrocket from year to year. The Health Security Act will limit the amount by which insurance companies can raise their premiums each year. Since everyone will have health coverage, small businesses and individuals will no longer bear the disproportionate burden of paying a large hidden surcharge for care to the uninsured.

Under the Health Security Act, all employers in the region will pay 80 percent of the average premium cost to the purchasing alliances, or more if they choose, and employees and business owners will select their families' coverage from among the various plans in that area. Insurers will no longer be able to set the premiums for small businesses on the basis of that

group alone. Instead, premiums will be based on health costs for the entire region. Everyone under 65 who obtains insurance through their regional health alliance will pay the same premium regardless of age or health status. Insurers will no longer be able to reject businesses or individuals for any reason.

Small businesses and families will be eligible for significant federal assistance with premium costs. No business with under 5,000 employees will have to spend more than 7.9 percent of its payroll for health insurance costs. Businesses with 75 or fewer employees will pay less if their average wages are $24,000 or less. The lowest wage small businesses will pay only 3.5 percent of payroll. Families and individuals with incomes below 150 percent of poverty (about $22,000 for a family of four) will be eligible for assistance with paying their share (20 percent of average premiums) of the premium. Families with incomes under $40,000 will pay no more than 3.9 percent of their income for their share of the premiums.

Under the Health Security Act, the Maddux family would have comprehensive health benefits for the same premium as all other neighboring Texas residents. After paying a $250 annual deductible for each family member, they would be responsible for 20 percent of their prescription drug costs or $5 for each prescription, depending on their plan, until they had annual medical costs of $3,000. Once they spent that much, they would no longer have any out-of-pocket costs for a comprehensive range of services.

LONG TERM CARE AT HOME

Roz and Harold Barkowitz live in North Miami Beach, Florida. Harold is a 72-year-old retired shoemaker who had to give up his business six years ago to care for Roz, age 67, who has multiple sclerosis. They had to sell their house and move into an apartment because Roz could no longer climb the stairs. They get no outside assistance caring for Roz, only someone who comes to clean once a week. Harold's greatest fear is that something will happen to him and he will no longer be able to care for Roz. He currently spends 24 hours a day taking care of her.

Virtually every American family eventually confronts a long term care crisis. At any given time, there are an estimated three and one-half million Americans who have great difficulty taking care of themselves. These persons require assistance with three or more of the five most basic activities of daily living—eating, bathing, toileting, dressing and getting out of a bed or chair. The services that they need are largely non-medical in nature and, as a result, options for financial assistance or insurance coverage are very limited.

Approximately half of these Americans currently do not receive any paid home care services.[18] They want to continue to live in their homes and communities rather than go to a nursing home. But they and their family caregivers need help. Based on one study, families devote an average of 57 hours per week to caregiving for their frail elders.[19] Over one-third of informal caregivers are elderly and one-third report being in poor health themselves.[20] Currently American families that use paid home care must spend thousands of dollars out of pocket for that care.[21]

The Health Security Act establishes a major new program to provide services to individuals with severe disabilities without regard to age. Beginning in 1996, under the Act, the federal government will provide significant new funds to states to enable the development of individualized plans of care for persons with severe disabilities. These persons will be eligible for services that include personal assistance and other services that help these persons continue to live in their homes and community. This new program will be fully phased in by the year 2003. Individuals will be responsible for copayments based on income.

Under the Health Security Act, Mr. and Mrs. Barkowitz would be eligible for the services of someone to assist Mr. Barkowitz with caring for his wife. The new program will make such care affordable. With a major federal program supporting home and community-based services, it would be easier to find appropriate assistance for Mrs. Barkowitz.

EMPLOYEES VULNERABLE TO ARBITRARY BENEFIT LIMITS

John and Joan Cleveland of St. Louis, Missouri had health insurance through Joan's employer, a company that is self-insured. John was diagnosed with leukemia in September 1990, and he needed a bone marrow transplant. Even though his insurance had a $500,000 lifetime maximum, the policy capped coverage of organ and tissue transplants at $75,000. John's transplant cost about $250,000. John died of complications from his transplant in June 1993.

Approximately 40 percent of all employees and their families are covered by employer health plans that are self-insured.[22] Self-insured companies do not purchase health insurance from a private insurance company. Instead, they pay the cost of their employees' medical care directly.

The federal Employee Retirement Income Security Act of 1974 (ERISA) protects the financial solvency of employee benefit plans, like retirement and insurance plans. This law exempts self-insured employers from state mandates, regulations and premium taxes. As a result, the U.S. Supreme Court recently ruled that self-insured employers may limit or eliminate health insurance benefits at any time, even after an employee or a family member contracts a serious illness. As a result, employees of self-insured companies have found themselves in the tragic position of developing very serious illnesses and watching employers respond by limiting benefits for that illness—with employees having no recourse.

Self-insurance was once common among only the largest firms. However, smaller and smaller companies are now choosing to self-insure in an effort to save money. Self-insurance is now common with companies with as few as 100 employees. In 1986, only 46 percent of all employers that offered health insurance were self-insured. By 1992, 69 percent were self-insured.[23]

Upon enactment, the Health Security Act will prohibit all employers and insurers from imposing caps or exclusions on coverage for specific medical conditions or any lifetime limit on benefits. The Act will require all businesses, whether they

pay for their employees through a regional health alliance or through their own health alliance, to provide the comprehensive benefits specified by federal law or to offer even more extensive coverage.

Under the Health Security Act, John and Joan Cleveland would have had to pay no more than $3,000 out-of-pocket for John's medical expenses in the year that he had his bone marrow transplant.

EMPLOYERS WITH SKYROCKETING PREMIUMS

Roger Flaherty owns a small company, Floor Covering Resources, in Kensington, Maryland. He has two employees, and they are covered by a small group health insurance plan. Both employees have ongoing health problems. In 1987 Roger paid $285 a month to cover these employees. He now pays $786 a month. In november 1993 his premiumms will increase to $946 a month. The business pays the full cost of the insurance. Roger is committed to providing health insurance for his employees, but doesn't know if he can continue to afford it.

The amount American families and businesses are charged for health care has far outpaced increases in family income and business profits. Average family income increased 88 percent from 1980 to 1991, while average family spending for health care increased 147 percent. In 1992 alone, health care inflation caused the equivalent of a five percent cut in American families' take-home pay.[24]

Today, business spending for health care nearly equals the amount corporations make in after-tax profits.[25] By contrast, in 1980, business health care spending amounted to 41 percent of corporations' after-tax profits.[26] If health care inflation had been held to the same rate of inflation as in the rest of the economy from 1980 to 1992, health care costs for businesses today would be one-third less than they are. This difference averages about $1,000 per worker.[27]

By 1996, the Health Security Act will limit the amount by which insurance companies can raise premiums. By 1999, American families will no longer have to swallow health insurance premium increases that are larger than general inflation. American families will see larger wage increases and more disposable income and businesses will see less of their profits eaten up by health cost increases.

Under the Health Security Act, Mr. Flaherty would see his health insurance premiums for his employees go up no faster than inflation.

CARE UNAVAILABLE FOR MEDICAID BENEFICIARIES

In late 1990, Sherri Wilburn of Blount County, Tennessee learned she was pregnant. Although she qualified for Medicaid coverage, neither Sherry nor a social worker at the local health department could find a doctor willing to provide Sherri with prenatal care. Sherri was finally able to schedule her first doctor visit for a date in her seventh month of pregnancy.

Three days before her scheduled appointment to begin prenatal care, Sherri went into labor. Her daughter, Cassandra, was born with brain damage and was hospitalized for months. Cassandra will need special education and ongoing physical therapy. According to one of Cassandra's doctors, Sherri's pregnancy was "complicated by a lack of prenatal care."

Low-income Americans face numerous barriers to medical care, even when they are covered by Medicaid, the government's health insurance program for low-income persons. Approximately one of every five adults who receives Medicaid experiences problems getting health care. Last year, almost one out of five adults receiving Medicaid were turned away by a hospital or a doctor. Another 20 percent had to go to an emergency room for care because they did not have a regular doctor.[28]

Doctors are often reluctant to see Medicaid beneficiaries because Medicaid pays far less than private insurance for medical care. One-quarter of all physicians will not accept any Medicaid patients. Another one-third limit the number of Medicaid recipients they see. Over half of all pediatricians report that they will not accept any Medicaid recipients, or limit the number they will accept.[29]

Under the Health Security Act, all Medicaid beneficiaries will have access to the same plans offered by the regional health alliances as everyone else. For individuals eligible for Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC), the Medicaid program will make payments to the health alliances that allow the beneficiaries to choose among all health plans with premiums equal to or below the average. Persons currently receiving Medicaid, but not eligible for cash assistance, will obtain their health insurance through their regional health alliance in the same manner as all other persons. Additionally, persons who receive cash assistance will pay discounted copayments.

Under the Health Security Act, Sherri Wilburn would have her choice of any insurance plan offered in her Tennessee region with an average premium or lower. All such insurance plans would have to provide easily accessible prenatal care. Her regional health alliance would provide her with information on the quality of prenatal care provided by each plan offered in her region.

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29. John K. Iglehart, "The American Health Care System: Medicaid," *The New England Journal of Medicine* vol. 328, no. 12. (March 25, 1993), pp. 896-900.

Mr. REED. I think you provided a good jumping off point for my first question to the panel, and that is, one of the critical differences between the various plans that have been proposed is the mandate by employers to provide insurance versus Senator Chafee's proposal of an individual mandate. I wonder if you all might comment on the practicality and advisability of the individual mandate versus the employer-based mandate.

And you might start, Mr. Pollack, and go down the panel.

Mr. POLLACK. I am happy to do that, Mr. Reed.

There are really four different approaches that we see in the various bills that have been introduced so far. One approach, essentially, as Congresswoman Woolsey mentioned, is the single-payer approach. I believe that that approach effectively achieves coverage for everybody. It has worked in Canada. It could work here in the United States.

There is a question as to politically whether it is achievable in this Congress, but I think it could work and it certainly has worked in countries that have tried it. I have already gone over the employer mandate approach.

The third approach is the approach utilized in the Chafee bill, and I think the individual mandate has two disadvantages to it. It theoretically can achieve universal coverage, but I think it has two problems.

The first problem is that in order for that to work the subsidies that the government is going to have to pay to employees are considerably larger than the subsidies and the expenditures the government will have to pay through an employer mandate. For a simple reason: The burden, in effect, is shifted on employers rather than the government, and if you shift that burden onto employees, then you're going to have to subsidize employees who are not just poor but those who are marginally above the poverty line. And I suggest to you that the fiscal implications of that approach are significantly more severe than they are under an employer mandate.

The second problem with an individual mandate is that I think it would encourage some businesses to drop current coverage that they are providing for their employees, and I believe that in turn the employees will not be made whole with an increase in salaries. I think very few employees believe that if you drop coverage that their employer is going to make up for that loss in fringe benefits through an increase in salary.

But even in those few instances where an employer did make up for it, the tax treatment of that increased salary is such that the net effect is not going to yield an employee being in the same position because the employee is going to have to pay taxes on that increased salary, which will mean in terms of take-home pay the net effect is going to be a loss of income and security for workers.

The final approach is actually the Cooper approach, which I view as the "wishful thinking" approach in all this, and it is—of the four, it is the least desirable of the various options.

The Cooper approach hopes that through some insurance reforms that more people will get coverage and it provides some modest subsidies for people. We certainly have some experience with insurance-based reforms and what the impact has been, and it has not come anywhere close to achieving universal coverage. So that the

Cooper approach is one that would leave many millions of Americans without health insurance whereas, theoretically, the first three approaches could work albeit I think the employer mandate has a far greater advantage to it than the individual mandate.

Mr. REED. Thank you, Mr. Pollack.

Ms. Davis?

Ms. DAVIS. We are opposed to an employer mandate from two perspectives. First of all, it is a tax on employment and will massively reduce employment opportunities in the country. But also precisely because it does build on what is wrong with the current system.

The fact that we have an employer-based system is why we have a lack of portability, why we hear stories about preexisting conditions, because people have to depend on their employers to provide them with health insurance. This is a middle man. It prevents consumers from having choices in the health care market. What we need to do is get back to where individuals have more control over the health insurance that they can buy.

An employer mandate just embeds exactly what is wrong with the current health care system, and on top of having massive unemployment in the country.

Mr. REED. Does your organizations support a universal health care system that every American should have access to?

Ms. DAVIS. Every American should have access to health insurance, and the best way to provide for that is to have a free market, which we do not have now, and to provide subsidies for individuals who can't afford to buy health insurance today.

We already as a society think that everyone needs to have food but the government doesn't run the grocery stores. We have vouchers for people who can't afford to buy food, and that system works pretty well, and that is what we should be doing.

Mr. REED. So you would propose a system in which we would provide vouchers to all Americans to purchase health insurance?

Ms. DAVIS. No. No. To people who can't afford it on their own, the way we do for food today.

Mr. REED. Food stamps. But the food market is a little bit different than the medical care market, I suspect. I mean most consumers have a pretty good idea what they want to eat and they can shop between Oreo cookies and Hydrox cookies. Do you think we can do the same thing in health care?

Ms. DAVIS. I think we would do it even better in health care. I mean whether I eat Hydrox cookies or Oreo cookies isn't going to have much of an affect on my life, but whether I choose a good doctor is certainly more important, not from a financial perspective, from my own health perspective.

I think every single person out there has very clear incentives to look into their own health care.

Mr. REED. Thank you.

Ms. Shearer, your thoughts?

Ms. SHEARER. I would like to first comment on the previous witness' response. If you take this to the extreme and you get rid of employment-based insurance and you focus on the individual, what this would lead to eventually would be charging someone with cancer a premium of $30,000, individual risk-based premiums. The

bigger the group for community rating, the better off less healthy consumers are.

And we strongly believe that health care is different from food and televisions and that we need to be turning to a community-based, community-rated type of premium.

But, to directly answer your question about the employer mandate, as I mentioned in my testimony, we continue to support a single-payer system as the best way to achieve universality. An employer mandate, however, is our second best alternative. If you're not going to adopt a single-payer system, then we believe that you need to have an employer-based mandate. We believe that this builds effectively on the present system. It levels the playing field between employers.

I would like to agree with some things Mr. Pollack said earlier about some concerns about an individual-based mandate. We are concerned that the needed subsidies of that type of approach could be certainly in the high tens of billions, possibly over $100 billion, to bring the cost down to an affordable level for the lowest income people, and we are also concerned that employers could cut back on their employment-based policies if there were an individual mandate.

Mr. REED. Thank you.

Ms. Cain?

Ms. CAIN. Yes. Our members when they studied this issue decided that they felt single-payer was the preferred way but could—found acceptable an employer mandate if it did give you universal coverage and cost containment. Did not find acceptable the individual mandate which in many cases people who are currently not under an employee system now have to, as Ms. Shearer indicated, certainly live that way and can't afford coverage when they are out there by themselves, and that system really doesn't seem to work and doesn't give coverage.

We want people to receive quality health care, not access to the ability to buy it. So we feel that—we prefer the other two methods.

Mr. REED. Thank you very much.

Ms. Woolsey?

Ms. WOOLSEY. Well, now I know why I am such a happy member of the League of Women Voters.

Ms. CAIN. Thank you.

Ms. WOOLSEY. I have just completed five of seven health care forums in my district and I have had a League member on each of the panels whenever it was possible, and I have found that a very balanced viewpoint.

Ms. CAIN. Thank you.

Ms. WOOLSEY. With the balanced viewpoint from the League, nonpartisan, how are you getting your proposal out, so the rest of the world can see it, in the United States?

Ms. CAIN. Well, we are trying very hard to—we have had the opportunity, thank you, to appear before panels such as yours here and to work with members in the grassroots across the country and hope to do more of that and be able to put together—we put together a health care kit for citizens so that they could take a look at the issues.

Am I addressing your question?

Ms. WOOLSEY. Yes.

Ms. CAIN. Well, we put together a health care—it is called a care package for citizens that deal with the major issues so they can make up their minds as well on what needs to be done in health care reform, and that is available to everybody. It talks about the process that you will go through as Members of Congress, what committees will be dealing with it, and how they can get access to you to discuss the issues.

Ms. WOOLSEY. Well, I would suggest you promote that as best and widely as you can.

How are we going to be able to keep reproductive services, including abortion, in the President's plan?

Ms. CAIN. Well, we feel that it is critical and we will do everything we can. We are happy and delighted that it is in there and we will do everything we can to see that it stays.

Ms. WOOLSEY. Thank you.

Ms. Shearer, does your organization have polling data? Do you have focus groups? How do you know what the consumers want so clearly?

Ms. SHEARER. We did a poll with the Gallup organization in the spring that found that 85 percent of American consumers want a health care system that is not based on age, income, health status, or employment. We did a poll in 1939 that showed that people were willing to pay, I believe the figure was $3—$3 a month for health care coverage. If we had only done what we had recommended in 1939 we wouldn't be where we are today.

We don't do polls frequently. But, as I mentioned, we did a poll in the spring that showed to us very clearly that Americans not only want a system that is separated from health status, but they also want a system with very comprehensive benefits.

And one other key finding of our poll was that 90 percent of the consumers that we polled, and this was a random cross section of Americans, supported including benefits beyond doctor care and hospital care and preventive care, but also including nursing home benefits and home care benefits.

Ms. WOOLSEY. And did they feel that a choice of provider would really be available through fee-for-service?

Ms. SHEARER. Well, our poll preceded the Clintons' initial proposal, but what it found was that freedom to choose providers is something that Americans feel very, very strongly about. And our analysis of the Health Security Act, the Act as introduced in October has improved dramatically on the draft in September because it does provide a safety valve to consumers.

If a consumer joins an HMO at the beginning of the year when they are healthy and find that they get sick down the road in the middle of the year, they will have the option of going outside the network to find the most renowned specialists that they may need, and we think that provides an important protection to consumers.

We feel that the plan should go further in making sure the fee-for-service option is available to people of all income levels, so we feel that the plan needs some improvements in that area.

Ms. WOOLSEY. Okay. Mr. Pollack, if the single-payer system is politically acceptable to the public, why do you think it is not politically acceptable to the Congress?

Mr. POLLACK. Let me repeat. I think a single-payer system can work well. It is very effective. We have written a book about the single-payer system and observed its functioning in Canada.

I think my own judgment as to why I think it is not likely to pass the Congress—that has nothing to do with my viewpoints about whether it would be good to pass the Congress—is that if you look at what happened in the budget fight, in the budget fight that ended this summer we were trying to cut the deficit by $500 billion over 5 years. That is $100 billion, of which half of that was to be in new taxes, the other half was to be in expenditure reductions. So in terms of new taxes, it was about $50 billion in new taxes.

Now, if we implemented a single-payer system it would require that those expenditures currently made in the private sector would have to be made through the public sector, and that would be about $500 billion.

Now, I believe that you can achieve significant savings through a single-payer system, but the tax implications are $500 billion, or about 10 times as great as what we experienced in the budget battle. And given that in the Senate the vote was 50 to 50 with the Vice President breaking the tie and in the House it was a two vote difference, I have my doubts as to whether this Congress was likely to adopt that approach.

Now, I do favor, as Gail Shearer talked about, the President's proposal to allow States to test with a single-payer approach, and I think there may be a few States that may be willing to opt into it. Vermont clearly is looking at this. The District of Columbia is looking at this, and there may be some other States.

So I think for those of you who support a single-payer system, I think that the feature that Ms. Shearer emphasized before about the option for States to go in a single-payer direction is very helpful, and I support that.

Ms. WOOLSEY. Okay. Thank you.

Mr. REED. Mr. Hoekstra?

Mr. HOEKSTRA. Thank you. A couple of questions for the entire panel.

The benefits package that the President's plan has has been described as equivalent to the best in a composite of the Fortune 500. Have any of you done a survey of medium-size companies, Fortune 500 companies, that identifies the 5 or 10 companies that have really taken a leading-edge approach to controlling health care costs?

I have a company in my district that has reduced their health care costs by 30 to 40 percent through an aggressive wellness program, providing incentives to their employees to live healthy lifestyles, which has provided significant benefits back to the corporation.

I don't see any of those elements in the President's plan, and I am wondering if any of you have done a survey that would show the best companies out there today, and what they are doing. Here is where it is benchmarked. And here is how the President's plan stacks up to that.

Have any of you done anything like that?

Ms. SHEARER. No.

Mr. HOEKSTRA. No. So, we have 500 Fortune 500 companies out there and we have been studying health care and none of you have taken a look at companies that have been wrestling with this problem for the last 10 years, trying to get costs under control, some of them very successfully, and we don't know what their experiences are. I asked this question last week of somebody in the administration and they didn't know, so I am not surprised. But it is amazing to me.

Ms. CAIN. But there was a survey done last summer by Foster Higgins consulting firm that said that more than half of the 2,448 big companies that were surveyed, that they had their workers enrolled in a managed care program. So at least half of some of the larger companies are at least looking at alternative ways and managed care was—half of them had assumed, I guess, that that was a good way to go.

Mr. POLLACK. The other thing is I am sure the administration or any bill can do a whole lot more with respect to improving healthier lifestyles and certainly preventive care. At least the administration has taken some, I think, helpful steps in the direction of preventive care.

One of the financing devices, I think, is very helpful in that direction. The 75-cent increase in cigarette taxes, hopefully, is going to reduce cigarette smoking. The fact that preventive care is accentuated in this package, and that the various preventive care services, unlike the other services in the plan, do not have copayment features in them, so that they try to induce people to get wellness care as opposed to sickness care. I think that is an improvement.

Now, I am sure the administration can do a whole lot better, and we all can do better in looking at some other ways that we can promote healthy lifestyles. But I think the administration has made a helpful start in that direction.

Mr. HOEKSTRA. I would think that if you had looked at the Fortune 500 you may find that the elimination of copayment may or may not be a good idea.

Mr. POLLACK. I was not saying that one should eliminate copayments across the board.

Mr. HOEKSTRA. Yes.

Mr. POLLACK. There is an argument to be made that the copayments provide a greater cost consciousness.

However, I think that we don't want that cost consciousness to interfere with people receiving preventive care and the earliest care, and I think it is a smart thing to waive copayments for preventive care.

Ms. DAVIS. I haven't seen a survey of all 500 but there are some examples of very innovative firms out there. One that comes to mind is Forbes I know introduced a plan for its employees, and I may not get the numbers exactly right because I can't remember completely, but they basically told their employees that the first $500 of health care expenditures they would pay in cash, and every dollar of that $500 that an employee didn't spend he would get $2 back in a bonus at the end of the year.

And I, again, like I said, I don't have the numbers with me, but they claim this has provided massive cost savings in health benefits. They have been able to keep the rates of increase fairly low,

very much lower than the national average increase in health plans.

I mean there are some very strong market-based incentives going on out there in the large companies, and they are working. And the Clinton health care plan would undermine a lot of these efforts.

The important thing about the mandated benefits package, if you have a—anytime you try to come up with a one-size-fits-all policy it is going to have to be huge to fit everyone in it. But the fact of the matter is that you are going to have a little plastic card and it says that you are going to be able to get all these benefits, but you are going to have to go through some kind of a gatekeeper situation where you may—your little card says you are entitled to all these benefits, but you have to get through the doctor to let you go to a specialist and actually take advantage of them.

There is a big difference between having health insurance and getting health care. Everyone in Canada has health insurance, but they don't get health care. That is one of the things that is getting distorted in a lot of the debate over this issue.

Mr. HOEKSTRA. Thank you very much. I would hope that one of you could take the lead in doing a survey and trying to find the benchmark companies out in the marketplace and find out what is making them successful and make some recommendations in terms of how they might improve the President's health plan, or maybe the President's health care plan has all those elements incorporated into them already.

Thank you very much.

Mr. REED. Thank you very much for your very thoughtful and informative testimony. Again, thank you.

Ms. SHEARER. Thank you.

Mr. REED. Before we ask the second panel to come forward, we will take a short, we hope, recess of approximately 15 minutes, so that will give everyone a chance to go over their notes.

Thank you very much.

[Recess]

Mr. KLINK. [presiding] Bring our hearing back to order.

For our second panel we have three witnesses: Alissa Fox, the Executive Director of Congressional Relations for Blue Cross-Blue Shield—we welcome her with us today; Michael Berumen—I hope I pronounced that correctly——

Mr. BERUMEN. Yes, sir.

Mr. KLINK. [continuing] Senior Vice President of Pacific Mutual Group Life Insurance Company of Falcon Valley, California; and Douglas Freeman. Douglas is President and CEO of Medical Benefits Mutual Life Insurance Company of Newark, Ohio.

And I believe we will start with Ms. Fox.

STATEMENTS OF ALISSA FOX, EXECUTIVE DIRECTOR, CONGRESSIONAL RELATIONS, BLUE CROSS/BLUE SHIELD; MICHAEL BERUMEN, SENIOR VICE PRESIDENT, PACIFIC MUTUAL GROUP LIFE INSURANCE COMPANY, FALCON VALLEY, CALIFORNIA; AND DOUGLAS FREEMAN, PRESIDENT AND CEO, MEDICAL BENEFITS MUTUAL LIFE INSURANCE COMPANY, NEWARK, OHIO

Ms. Fox. Thank you. I am Alissa Fox of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield Plans provide coverage to 67 million people. Over one-third of our enrollment is in managed care networks.

The Blue Cross and Blue Shield Association strongly supports the President's objectives for health care reform: health care coverage for everyone, strict new standards for insurers and cost containment through managed care networks. We very much want to work with this committee to see reform enacted in 1994.

We believe strict Federal standards for insurers is the first and most important step.

I cannot overemphasize the significant impact of insurance reform on carrier practices. Right now insurers are competing on risk selection, trying to identify healthy groups and offering them coverage and excluding the sick.

It is easy to understand why this is. Four percent of any population will generate about 50 percent of all the claims costs. Many insurers, if they have the choice, will invest in techniques to avoid those high risks rather than investing in techniques to manage costs. These practices need to stop. Health plans must be required to take all comers and set premiums fairly, and self-funded plans must play by the same rules.

We believe the best way to control costs is to create incentives for consumers to use the most cost effective health care plans. We need to make it possible for the first time for consumers to buy insurance just like they buy other products, by evaluating quality and shopping for the best price.

We support standardizing benefit packages, requiring health plans to report standardized data on quality of care, and revising tax policy to promote cost-conscious decisionmaking.

And finally, every American should have health coverage. We believe the fairest way to accomplish this is through a requirement that employers contribute to the cost of the package with subsidies for small employers and low income individuals.

Under the President's proposal, these reforms do not begin until States create Health Alliances. We believe that hinging reform on having Health Alliances up and running will delay reform and jeopardize its success. Moreover, we don't believe mandatory Health Alliances, large or small, are needed to achieve the objectives of universal coverage and cost containment.

First, the administration says that the Health Alliances are needed to pool purchasing power. It is important to understand that under the administration's proposal the Health Alliances is not what gives groups better rates, but instead it is the new Federal requirement that health plans must community rate their business; that is, the health plan must offer their best rate to everyone in the market because they must sell coverage to everyone

at the same exact price. The community rating requirement is what gives everyone the best price and you don't need an alliance to do that.

Proponents of Health Alliances argue that alliances are needed to reduce administrative costs. We believe this is best accomplished by standardizing benefits, reducing marketing costs, eliminating paperwork for consumers, and standardizing forms for providers. Large mandatory alliances as proposed by the President would increase administrative costs by duplicating functions performed by health plans today and employers who won't stop doing many of those same functions.

Finally, we don't believe alliances are needed to offer individuals an expanded choice of health plans. Large employers today often offer several different types of health plan options for their employees. Small employers could offer similar options or could participate in a voluntary alliance to allow their employees to choose from a menu of plans.

Besides the fact that alliances aren't needed, people underestimate the magnitude of their responsibility and what will be duplicated by these new entities. Managing the enrollment and premium collection of millions of individuals within a one or two-month annual open enrollment period is truly an enormous undertaking that is fraught with complexity.

Thank you very much.

[The prepared statement of Ms. Fox follows:]

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, and members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million people. I appreciate the opportunity to testify on the Health Security Act of 1993.

Insurance Reform: The Foundation of Health Reform

There is a consensus across this nation and in Congress that insurance reform is one of the central elements in comprehensive health care reform. Fundamental changes in the basic rules within which insurers operate is a key component of the major health care reform proposals.

As Congress begins the debate on health care reform legislation, I cannot overemphasize the significant impact of insurance reform on carrier practices. The types of insurance reforms that I will discuss would move the market away from competition based on risk selection. Risk selection is the reason we do not have true price competition in health care. It is easier for many insurers and Health Maintenance Organizations (HMOs) to hold down costs by screening out high risks than by managing overall health care costs. A clear illustration of this point is that 4 percent of any population will generate about 50 percent of all the claims costs. Many insurers, if they have the choice, will invest in techniques to avoid those high risks rather than invest in techniques to manage cost.

Insurance reform eliminates risk selection as a tool for maintaining competitive prices. Instead, insurers would have to compete on the basis of their ability to manage costs.

We believe that strict federal standards for the market conduct of insurers is the first and most important step toward reshaping the health care market -- and assuring fairness to consumers. Federal standards defining a health plan should:

1. Require insurers to accept everyone regardless of their health status or employment;
2. Strictly limit the length and use of waiting periods for pre-existing conditions and prohibit them entirely for people who have been continuously covered;
3. Prohibit insurers from dropping people or groups when someone gets sick and require insurers to offer continued coverage when a person loses his or her job;
4. Require insurers to set premiums fairly and not penalize people who are sick or older; and,
5. Require insurers to comply with requirements for administrative simplification, including increased reliance on electronic data interchange and conformity to standards.

These same strict standards must apply to more than insurers and HMOs. Self-funded plans must play by the same rules and be held to the same standards as health plans.

<u>Insurance Reform By Itself Is Not Enough</u>

While new rules for insurers are an essential part of health care reform, by themselves they will not be sufficient to contain costs and achieve universal coverage.

Cost controls: New standards for the way insurers do business can be an underpinning of a successful cost containment strategy. In addition, insurance

reform will allow individuals, employers and employees to weigh both price and quality when purchasing coverage by requiring:

1. Standardization of health benefit designs. While we do not believe a single standardized benefit design will be workable, a limited number of standardized benefit designs will allow consumers to easily compare products.
2. Health plans to report standardized data on quality of care and subscriber satisfaction.
3. A limit on the tax deductibility of employer contributions for health benefits to an amount consistent with cost-efficient health plans.

These features will encourage the expansion of organized delivery systems that have a proven ability to change inefficient and ineffective utilization patterns and cause providers to become more efficient providers of health care.

Universal coverage: Making more affordable insurance available would reduce the number of people without insurance benefits, but it would not lead to universal coverage. A requirement for employers to offer and contribute to the cost of health benefits, and for individuals to accept and pay for the balance of the premium, would be necessary to achieve universal coverage.

Such a requirement, however, would impose a severe burden on many small employers. To make it possible for small employers to comply with the mandate, subsidies would be needed. These subsidies should be targeted to companies that rely heavily on low-wage workers.

Need to Increase Competition and Maintain Stability

Two elements of the Clinton Administration's recent proposal cause us concern. These include the proposal's reliance on large regulatory health alliances to

perform an extraordinarily broad and complex range of functions, including compliance with the new standards of market conduct, and the proposal's reliance on global budgets and premium caps to control costs. We do not believe either large alliances or premium caps are necessary to achieve the goals of universal coverage and cost containment. Instead, we are concerned that both may lessen the effectiveness of the new rules governing the insurance market.

Large regulatory alliances:

Under the Clinton proposal, all individuals and families in firms with less than 5,000 employees would enroll in a health plan through a regional alliance. Individuals would enroll in the regional alliance in the area in which they reside. There would be one alliance per geographic area, and the alliance would contract with all state-certified health plans. Each individual would enroll in a health plan through the alliance as an individual; employers would have no role in selecting coverage or overseeing the health plans used by their employees.

We do not believe that mandatory health alliances -- large or small -- are necessary to achieve the goals of cost containment or universal coverage. All but one of the functions envisioned for the health alliances are, or could be, accomplished through strict federal standards for insurance reform combined with stronger incentives for employers and individuals to purchase cost-effective health plans -- without adding a new administrative layer.

- States, not alliances, would assure that all individuals and small employers have access to coverage by requiring all health plans to: accept all applicants regardless of their medical or employment status; not drop an individual or a group because of medical problems; and set premiums in a way that does not penalize older or sicker workers.

- States would require health plans to set rates for large community-rated pools so that individuals and small groups have the same ability to pool high-risk and low-risk individuals as large employers. Even under an alliance structure, the "pooling" takes place at the health plan not in the alliance.
- Requirements for administrative simplification would reduce administrative costs by standardizing benefits, reducing market costs, eliminating paperwork for consumers and standardizing forms for providers. Large, mandatory alliances would increase administrative costs by: 1) moving several thousand employer transactions to millions of individual transactions and 2) duplicating functions of health plans that must continue.
- An alliance is not needed to negotiate with health plans on behalf of individuals and small groups. If health plans were required to charge the same rates for all individual and small group enrollment, all health plans would have an incentive to drive the best bargain for everyone. Limiting the amount of tax-free coverage that employers and consumers can purchase to the cost of an efficient plan, and giving employers and consumers the information they need to select a health plan based on price, performance and service levels would cause health plans to compete vigorously on price.
- Risk adjustment to account for some health plans enrolling a disproportionate share of older or sicker individuals could be accomplished just as easily outside an alliance through an independent agency operating under the supervision of the state insurance commissioner.
- An alliance is not needed to offer individuals an expanded choice of health plans. The choices available to individuals can be expanded in a number of ways without creating a large, mandatory alliance. Large employers today

often offer several different types of health plan options for the employee and could be required to do so. Small employers could offer similar options or could participate in a voluntary alliance to allow their employees to choose from a "menu" of health plans.

- An alliance would be necessary to administer indirect subsidies. Such indirect subsidies would result from:
  - — allowing states to purchase coverage for Medicaid recipients at 95 percent of what the state is currently paying for Medicaid benefits. Many states currently pay providers at rates that are below prices established in the more competitive private market. If state payment rates are, for example, even 75 percent of those prevailing in the private sector, then the cost of providing the guaranteed benefits package for Medicaid recipients could exceed the state's premium payment by more than 40 percent.
  - — Individuals or employers who fail to pay premiums would continue to receive coverage (health plans are prohibited from dropping individuals for nonpayment), and their bad debts would be spread across all other employers and individuals through an assessment on premiums.
  - — Premium payments by employers for part-time workers may fall short of the employer's share of the premium, requiring full-time workers to pay more for coverage.

  However, we believe these costs should be subsidized directly rather than "hiding" them in a complex alliance structure.

Premium Caps and Global Budgets: Global or alliance budgets administered through premium caps promise less spending, but we believe they would prove to

be ineffective and would preclude a smooth transition into a more competitive and efficient system.

1. Premium caps would be driven by federal budget priorities and politics that have little or nothing to do with health care. One decision in Washington would determine the amount of money available to provide needed health care in each health alliance area.
2. By relying on a process that is not a reliable predictor of how fast communities should be expected to eliminate inefficiencies, premium caps would force the rapid downsizing of provider networks, reduced availability of sophisticated diagnostic and treatment technology, increased waiting times for consumers, and a decline in customer service. Plans that cannot comply with the limits would either be forced from the market -- or forced into insolvency. The end result would be fewer choices for consumers.
3. Premium caps would limit the innovation needed to truly change behavior, by limiting the ability of health plans to invest in ways of better managing practice patterns and achieving better outcomes for their members.
4. In the absence of proven methods of risk adjustment, health plans could exceed their premium cap because they have enrolled higher-risk subscribers not because they do not effectively manage costs.

Although some argue that premium caps are needed to enforce limits on spending, we believe that the new rules for health insurers will lead to vigorous price competition that will be more effective in controlling costs over the long run and support a more orderly transition into a reformed health care system.

Conclusion

I would like to reiterate our strong belief that insurance reform is the key to containing costs and assuring access to coverage. Reforms are needed to make coverage available for employers that have an employee who has a serious medical condition, reduce the wide variation in premiums charged to groups based on their health status, limit increases in premiums for small employers that result when an employee develops a serious medical problem, and assure coverage for individuals with existing medical conditions.

Federal policies to give employers and individuals a greater incentive to select cost-efficient health plans that delivery high quality care, and to enable them to compare the options that are available in a reformed market will complement insurance market reform. The benefits of reform can be realized without resorting to either premium caps or large health alliances that could actually work against the objectives of reform.

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Mr. KLINK. Thank you.

Mr. Berumen?

Mr. BERUMEN. Thank you, Mr. Chairman. I would like to enter my previously submitted written remarks for the record and summarize orally, if I may.

I am with PM group, a wholly-owned subsidiary of Pacific Mutual Life Insurance Company. We specialize in employee benefits, and among the things we do is provide excess loss coverage to self-funded or self-insured plan sponsors.

Our company is also a member of the Self-Insured Institute of America and the Coalition to Preserve Self-Insurance, an alliance of various businesses dedicated to preserving self-funding under any reform scenario.

I would like to share just a few facts with you, if I may. It is my opinion that the whole self-funded arena has been a rather neglected area in the reform debate. It may surprise many to learn that the majority of plan sponsors today, some estimate as much as 60 percent or more, are under a self-funded or self-insured arrangement, not with a commercial insurer, not with an HMO, and not with a Blue Cross/Blue Shield arrangement.

Employers self-fund to create and manage a plan that suits their particular needs, the particular needs of the firm and the particular needs of their employee population.

Self-funded employers are responsible for much of the innovation that has transpired, much of the managed care, much of the cost containment, and much of the innovation in plan design. They are noted for being particularly administratively efficient, keeping paperwork to a minimum.

Self-funded employers generally aren't large enough to go without excess loss protection; that is to say, protection against a single large claim or a series of unexpected large claims. Therefore they purchase excess loss insurance to protect their firm assets and also their plan, and a continuation of the plan.

I do want to say that my company agrees with the need for a guarantee for health access for all Americans. I think that most people in my industry, the self-insured industry, agree with that as well. My company supports many of the President's views and many of the President's objectives. Our argument really has more to do with means than it does with ends.

There are three principal things with which my company disagrees, and I would like to summarize those for you and spend quite a bit of time on one of them. First, price controls, which historically simply haven't worked from the time of the Babylonians through President Nixon.

Second, community rating, pure community rating, which we believe will create unfair subsidies and be particularly hard on young, low-paid workers.

And third, mandatory and exclusive purchasing alliances which I believe will create a government-sponsored cartel of commercial interests. It will increase bureaucracy. It will increase the attendant costs of running a bureaucracy, and is guaranteed, in my mind, to be inefficient. I want to spend some additional time on this.

I truly believe that the concept of the purchasing pool is going to take away an employer's right to manage and control his expenditures. Employers will be asked to pay but will have no say.

The purchasing pool would, in effect, eliminate self-funding as a legitimate option for plan financing, an option which is popular and has been responsible for delivering benefits to millions of Americans. I think it is going to create an oligarchy, a cartel of interests, and we all know what happens throughout history with cartels. They will seek to optimize profit by rationing output, and I think that that is a necessary consequence of the type of arrangement that is being proposed.

I say that if these things are good, then let them compete in the marketplace. Most of the arguments posed against voluntary purchasing pools are, in my mind, quite specious.

I have 20 years of experience in employee benefits. I am a Democrat. I helped to elect the President, and I urge you to reject the concept of mandatory purchasing pools.

In conclusion, I also want to say that I think that the tone of the debate leaves something to be desired. If I may, I would like to say something on behalf of my associates in the insurance industry. We are good, hardworking, decent Americans, and I am unaccustomed to calling the people with whom I disagree deceitful or intentionally attempting to mislead me, and I don't think it is fair to call us misleading.

I think that people can disagree on issues, and particularly on the means of attaining shared objectives. We are not all greedy robber barons, even executives like me. We think we add value to the equation. And we know we are imperfect, but we think that our opponents in this debate are sincere people, reasonable people, and we believe that we should be extended the same courtesy and depersonalize these issues.

Thank you very much.

Mr. KLINK. Thank you, Mr. Berumen.

[The prepared statement of Mr. Berumen follows:]

Michael Berumen

Mr. Chairman, my name is Michael Berumen. I am a senior vice president of PM Group, a wholly owned subsidiary of Pacific Mutual Life Insurance Company. My company specializes in providing insurance and related services to employers sponsoring health benefits for hundreds of thousands of workers and their families. PM Group is one of the nation's largest providers of excess loss insurance coverage...or stop loss insurance, which protects employers with self-insured (also known as self-funded) group health plans against catastrophic and unpredictable losses. My company is an active member of the Self-Insurance Institute of America (SIIA), which represents a broad cross-section of employers, administrators, insurers and health benefit specialists with a common interest, namely, self-insurance. My company is also a member of the Coalition To Preserve Self-Insurance, an alliance of employers, insurers, and national business associations which supports the continuation of self-funding under any health reform plan adopted by Congress.

Permit me to offer the following facts:

- Contrary to what many may believe, the vast majority of employers providing group health plans are self-funded and do not fully insure their plans with commercial insurers, HMOs and Blue Cross and Blue Shield. Small, medium and large employers self-insure. According to a survey by A. Foster Higgins & Company, 67% of U.S. employers responding to the survey said they self-insured their group medical plans in 1992.
- Approximately 100 million employees and their dependents receive health coverage from self-funded group health plans.

- Employers self-fund to create and manage plans that suit the particular needs of both the firm and plan beneficiaries, thereby providing high quality and responsive health benefit programs to workers, while enabling the employer to have more direct control over plan costs.
- In recent years, a great deal of the innovation in plan design, managed care and cost containment has resulted from employers of all sizes that self-fund.
- A recent Self-Insurance Institute of America survey of employees covered under self-funded plans found that 94% were satisfied with the way their health claims were handled.
- Self-funded plans are noted for their administrative efficiency and for keeping paperwork to a minimum.

Excess Loss Coverage.

Most companies are not large enough to go without protection against large individual claims or an abnormal fluctuation in total claims from plan beneficiaries. These employers generally purchase stop loss insurance as a bulwark against financial hardship for the company or the plan. By increasing the financial stability of the firm and the plan, there are obvious advantages to the workers and their families.

The employer and the stop loss carrier agree upon the amount which the employer will self-fund in a given period. If the claims exceed this predetermined amount, the excess of that amount is reimbursed by the insurer. One very important distinction between stop loss and traditional insurance is that the stop loss carrier does not determine or adjudicate the benefits of the underlying benefit plan. With self-funding, this is the

employer's responsibility. The stop loss contract serves to protect the employer against covered losses. This is akin to the reinsurance arrangements that insurers purchase to protect themselves against adverse claims experience.

The excess loss segment of the overall health insurance market is quite large and very competitive, with well over 200 domestic and international carriers. According to a recent Foster Higgens survey, 85% of self-funded employers purchased some form of stop loss protection in 1991.

The Administration's Proposal

The self-insurance industry recognizes the need to improve our health care system. We welcome the Administration's proposal as a constructive contribution to the health reform debate. We are committed to working toward passage of health reform legislation structured on a system of employment-based health benefits and market-driven cost containment.

While my company agrees that universal access to health care must be given high priority by Congress, we believe several of the means proposed by the Administration to attain this laudable goal are fundamentally flawed; namely, price controls, which simply do not work, as has been shown many times throughout history; pure community rating, which will create unfair subsidies and will be especially hard on low-income workers; and mandatory purchasing pools, which will promote government sponsored cartels, increased bureaucracy and its attendant cost, and inefficiency.

While price controls and pure community rating are bad enough, the most onerous and questionable feature of the President's proposal is the requirement that the vast

majority of employers must purchase their insurance through a government sponsored purchasing pool or health alliance. This will cause employers to cede control over the management and financing of their group health plans to the government and a privileged group of commercial interests. This mandate will eliminate the self-insurance option. While the President's plan purports to preserve the employer-based system...it does not, in reality. While it remains largely employer paid, it effectively removes an employer's control over where and how insurance is purchased and the means by which it is financed.

My greatest fear is that the mandatory purchasing pools will eventually consist of a small cadre of private interests...a cartel or oligopoly...given a sinecure by the government. This will not promote or "manage" competition; instead, it will eliminate it, thus impeding efficiency, innovation, and responsiveness to plan beneficiaries. And, whether one is dealing with steel, oil or health insurance...the natural economic consequence of a cartel is to optimize profit by rationing output. If government sponsored purchasing pools are a good idea, then let them compete in the laboratory of the marketplace. Let us have true managed competition. If the pools work, employers will flock to them. But, don't mandate that they give up time-tested alternatives that provide for workers' needs.

My company shares many of the President's views and objectives. But, we strongly believe that employers of all sizes must have the freedom to choose alternative methods of funding and purchasing health benefits. With that said, we also believe there is a need for more uniform protection of plan participants, including underwriting reform.

However, as a nation, we should not and we cannot afford to throw out all that is good about our employer-based system. As an industry, we can embrace managed competition, but we are against the managed coercion that is implicit in aspects of the Administration's proposal.

As someone with nearly 20 years of experience in employee benefits, as a Democrat who helped to elect the President, and as an American who wants serious reform, I urge that you reject mandatory and exclusive purchasing pools and that you preserve those methods which are of proven value in our employer-based system, including the self-insurance alternative.

On a final note, I want to say that the tone of the debate has deteriorated and, in my view, has not always served the interest of the public. Indeed, those of us in the health insurance business are like most other people, including elected officials, government workers, and people in other businesses...decent and hardworking people who take pride in what they do and think they add value to society. I, for one, believe all of the principals in the debate are sincere in their beliefs; that reasonable people can disagree, especially with regard to the means of attaining shared objectives; and that we must depersonalize the competition among ideas. Then, and only then, will we be able to work together to fulfill the President's vision of meaningful reform.

Mr. KLINK. Mr. Freeman?

Mr. FREEMAN. Good morning, Mr. Chairman, and members of the subcommittee. I am Doug Freeman, President of Medical Benefits Mutual of Newark, Ohio.

I am here on behalf of the Health Insurance Association of America. As you probably know, HIAA is an industry trade group representing 270 commercial insurers providing insurance coverage to about 65 million Americans.

Mr. Chairman, with your permission, I would like to submit my written statement for the record.

Mr. KLINK. Without objection.

Mr. FREEMAN. Thank you.

I want to thank you also for the opportunity to appear before you. I was anxious to appear, and my remarks are based on an initial review of the Health Security Act.

Comprehensive health care reform is the Nation's highest domestic priority now, as it should be. It is said that 37 million Americans are without health insurance coverage and many others are without the coverage that they need, particularly with regard to preventive services, and many fear they may even lose their coverage if they change jobs.

Health care costs continue to spiral upward. No question, the system needs to be reformed, and we, the Nation's commercial insurers, readily agree. The President has correctly identified the six principles on which true reform must be built. We agree with the President and the many Members of Congress who have developed reform proposals founded on these principles. HIAA's own vision for health care reform is predicated on these principles. Despite what you read, let me tell you where the HIAA stands and why I think we share much in common.

Here are some examples of what we are for: We are for cradle-to-grave coverage for all Americans; no exclusions for preexisting conditions; coverage that cannot be canceled if you get sick; if you change jobs or lose your job, we want the coverage to go with you; we are for employers and employees both paying towards the coverage; we are for subsidies for those who cannot afford premiums; we want to control malpractice lawsuits and unnecessary tests, or defensive medicine; we want to publish price and quality data; we want to eliminate the over-bureaucratic approach to insurance and get to a single claim form and control paperwork; we believe in wellness and promoting healthy lifestyles; we want to stop the cost shift in medicare and medicaid; and we believe and have promoted the use of managed care to control costs.

Mr. Chairman, the HIAA does have a few concerns regarding the Health Security Act. The first has to do with mandatory purchasing alliances. Aggregating purchasing power is the intended objective of Health Alliances in the President's plan, and we certainly don't oppose that theory.

The administration's bill requires anyone working for a company with fewer than 5,000 employees and all people with individual health coverage to enroll in the new alliance structure. In essence, that means that 80 percent of Americans, roughly 200 million people, will be forced to receive their coverage through an essentially untested alliance system.

In a mandatory approach, where do the millions of Americans go if the system doesn't work as envisioned by the President. The infrastructure that previously served them will no longer exist.

HIAA would favor having the government establish purchasing alliances on a voluntary basis. Under this system, employers and individuals would not be forced to purchase their coverage through the Alliance. Rather they would have the option of purchasing health plans as they do today.

All health plans, whether they participate in the Health Alliance or not, would have to play by the same rules, so that neither the Alliance nor plans operating outside the Alliance would receive an inequitable share of risk.

Insurance reforms such as the elimination of preexisting conditions limitations and guaranteed issue of insurance along with an appropriate risk adjustment mechanism would be applied to plans offered both inside and outside the Alliance. If Health Alliances are truly more administratively efficient and better at pooling risk, then the carrier operating through the Alliance will get a bigger market share and this voluntary approach would provide at least the opportunity to test the theory of the alliance approach.

Second, premium caps and price controls. While the Health Security Act does not contain the words global budget or national health care budget, the notion of capping health care spending is contained all throughout the administration's proposal. There is no question that health care costs growth needs to be curbed. HIAA believes that there are ways to cut costs without cutting care.

The administration proposal would, after a transition period, force insurers to constrain national health care spending at a rate no faster than the rate of increase in the Consumer Price Index adjusted for population growth.

To achieve this, the plan would cap premiums. Considering the dramatic growth in health care costs is only partially related to price, such a target would be difficult to achieve without radically affecting either the benefits or the services which people receive.

Also, implementing the President's plan would require between $30 and $90 billion in new capital. Premium caps, however, substantially reduce private investment, the source of capital. There would be no incentive for private investment in a price-controlled premium-capped market.

Mr. Chairman, starting down the road of price controls and premium caps would be an enormous mistake.

HIAA supports health care reform and we believe this committee has shown great leadership on this issue. We look forward to working with you, developing a comprehensive health care reform bill that achieves the objectives that we share in common.

Thank you.

Mr. KLINK. Thank you very much.

[The prepared statement of Mr. Freeman follows:]

DOUGLAS J. FREEMAN

Good morning, Mr. Chairman and Members of the Committee. My name is Doug Freeman, I am President and CEO of Medical Benefits Mutual Life Insurance Company of Newark, Ohio. I am here on behalf of the Health Insurance Association of America. HIAA represents approximately 270 commercial insurers covering approximately 65 million Americans.

Mr. Chairman, we commend the President for coming forward with an ambitious blueprint for reform of the nation's health care delivery and financing system. With approximately 37 million Americans currently without health insurance coverage, and health care costs consuming an ever greater share of the Gross Domestic Product, there can be no question regarding the imperative for comprehensive reform.

In his speech to a Joint Session of Congress on September 22, and again on October 27, President Clinton identified six fundamental principles on which any reform plan must be based: security, simplicity, quality, savings, choice, and responsibility. These are the same principles on which HIAA's own Vision for Reform was constructed last year. I would like to submit a copy of our Vision Statement for the record.

In communications with the Administration, Members of Congress, and the general public, HIAA has repeatedly stressed its wholehearted support for these principles, and has proposed specific means by which they can be implemented. Let me emphasize what we're for:

- "Cradle to grave" coverage for all Americans.
- No exclusions for existing or previous illness.
- Coverage cannot be canceled if you get sick.
- If you change jobs or lose your job, coverage goes with you.
- Employers and employees both pay toward coverage.
- Subsidies for those who cannot afford premiums.
- Control malpractice lawsuits and unnecessary tests.
- Publish price and quality data.
- Single claim form to control paperwork.
- Incentives for healthy lifestyles. Emphasis on wellness and prevention.
- Stop shifting costs of Medicaid and Medicare to those with private insurance.
- Using managed care to control costs.

While the HIAA strongly supports comprehensive reform built on universal coverage, we have serious doubts about many of the features of the Administration's plan. In the broadest sense, the President's plan erects an enormously complicated bureaucratic structure which could undermine, not foster an improved system. The HIAA believes it is appropriate for the government to establish guidelines and rules governing a

is appropriate for the government to establish guidelines and rules governing a reformed system. We do not believe, however, that government should, in fact, run the system.

HEALTH ALLIANCES

The President's bill calls for the creation of large, government-mandated purchasing pools through which everyone, except persons employed by an employer with more than 5,000 employees, must purchase insurance. The theory underlying this concept is that a large pool of purchasers will have significant market clout to bargain for low-cost health care -- market clout which small employers lack today. These mandatory government alliances will be responsible for contracting with State-certified health plans pursuant to the criteria established by a State under Title I, Part 1, Section 1203(a).

HIAA notes that the limitation on plan availability outlined in the Administration's September 7 "Working Group Draft" has not been retained in the bill. Under Title I, Part 2, Section 1321(a)(1) "... each regional alliance shall negotiate with any willing State-certified health plan...." While this does reflect an improvement over the "Working Group Draft," we cannot conclude that it has necessarily addressed completely concerns over plan availability. Under Section 1321 (b)(1) an alliance could reject a State-certified health plan if its proposed premiums exceed by 20 percent the weighted average premium within the alliance.

All individuals and employers with less than 5,000 employees will be denied a key choice in the new system -- they may not be allowed to retain their current insurance coverage or plan. Not all plans will be allowed to compete in the new system. What happens to those consumers who want to retain their current plan? Or purchase their coverage from an agent, who is, in essence, a benefits advisor to the employer? In a state which elects to establish a single-payer health care system, there will be no choices of health plan at all (Title I, Subtitle C, Section 1223(b)(2), page 111). This does not seem consistent with the goal of consumer choice or the goal of competition.

Proponents of these alliances suggest that significant administrative savings can be realized. HIAA believes such savings have been overestimated. Certain administrative functions must be performed by the alliance. These include plan enrollment, premium collection, claims payments, and fraud detection. Under the President's plan, enrollment is handled through the alliance. Today, employers handle employee and dependent enrollment. That cost is not reflected in their insurance premiums. Most employers send premium payments directly to the insurer or health plan. Under the President's bill, the alliance will not only handle enrollment, but will also collect the employer and employee share of the premium, forward premium payments to the plan selected by the employee, assemble and disseminate health plan marketing information, and negotiate fee schedules with providers. This can result in significant

administrative expense for the alliance when one considers that everyone except employees of the very largest employers in the region must purchase coverage through the alliance.

The Administration characterizes regional alliances as simple purchasing cooperatives providing individuals and small groups with buying leverage in the market. Their alliances are not simple purchasing cooperatives. They are organizations with huge budgets, considerable authority and a broad range of responsibilities. Laura D'Andrea Tyson, Chair of the President's Council of Economic Advisors, stated recently that the alliances will require 50,000 employees to operate them. The breadth and scope of activities of these regional alliances exceeds that of most existing agencies of state government today.

Health alliances are untested. The states that have authorized purchasing alliances in place have made them voluntary; only one is currently operational. The Administration's bill requires anyone who works for a company with less than 5,000 employees, and all people with individual health insurance coverage to enroll in the new alliance structure. In essence, that means that 80% of all Americans, roughly 200 million people [these numbers include everyone except 30 million Medicare recipients and 20 million workers and dependents whose employers would be eligible to establish Corporate Alliances. Source: "Congressional Health Care Workshops" materials dated September, 1993], will be receiving health coverage through an untested alliance system. There is no precedent for such massive change to a process so essential to the welfare of all Americans. After all, according to a June 1993 "Harvard School of Public Health" survey, 77% of Americans surveyed are pleased with their health care coverage.

One alternative to monopoly health alliances are voluntary health alliances. HIAA would favor having the government establish purchasing cooperatives or alliances on a voluntary basis. Under this system, employers and individuals would not be forced to purchase their coverage through the alliance, they would have the option of purchasing through the alliance or maintaining their current coverage. All health plans, whether or not they participate in the health alliance, would have to play by the same rules so that neither the alliance nor plans operating outside the alliance would receive an inequitable share of risk. Insurance reforms, such as the elimination of pre-existing condition limitations, and guarantee issue of insurance, along with a risk adjustment mechanism, would be applied to plans offered both inside and outside the alliance.

If health alliances are truly more administratively efficient, and better at pooling risks, then the carriers operating through the alliance will have lower premiums and will naturally gain market share. If, on the other hand, employers and individuals prefer to deal directly with an insurance company rather than a large government bureaucracy, they would have that choice. The market, not the government, should determine which is the more efficient way to insure all Americans. A voluntary approach would provide the opportunity to test the theory of the alliance approach, without gambling the

security and future of health care coverage for all Americans in the process. In a mandatory approach where do the millions of Americans go if the system doesn't work? The infrastructure that previously served them will no longer exist.

PRICE CONTROLS AND PREMIUM CAPS

While the Health Security Act does not contain the words "global budget or national health care budget" the notion of capping health care spending is contained all through the Administration's document. [See attached document "Budget Development and Enforcement (Premium Caps) For Regional Alliances in President Clinton's Proposed Health Security Act"] There is no question that health care cost growth needs to be curbed. HIAA believes there are many ways to cut costs without cutting care. Arbitrary price controls have never worked in our economy. The Health Security Act (Title VI, Subtitle A) directs the new National Health Board to set a baseline premium target for 1995. It then sets a national and local inflation factor for premiums in subsequent years. The inflation rate for premiums would be limited to no more than the CPI by 1998.

The HIAA commissioned the Washington National Tax Services of Price Waterhouse to compare the premium growth targets in the Administration's health care proposal and the actual growth in real per capita health care spending in twenty-four Organization of Economic Cooperation and Development (OECD) countries between the period of 1961 and 1991. Only four countries – Turkey, Ireland, Sweden, and Greece – held per capita health spending to a level that was comparable to CPI growth for one of the five-year intervals since 1961. Most countries have had rates of growth that are well above the rate of general inflation. In fact, during the most recent five-year period, three out of four OECD countries had growth rates that averaged 2.1% higher than the rate of growth in the general price level.

Considering the dramatic growth in health care costs is only partially related to prices (no more than one-third), such a target would be difficult to achieve without radically affecting either the benefits or the services which people receive. The lion's share of health care cost growth is attributable to growth in the use of health care services and the ever-increasing availability of new procedures and services. CBO issued a study last month questioning the efficacy of premium controls, saying they would have "undesirable consequences" such as "technological progress in health care would probably occur more slowly." "Effective limits on premium increases would affect both the quantity and quality of health insurance coverage available to consumers and their future access to new medical technologies."

Henry Aaron and Charles Schultze of the Brookings Institution have noted:

"Growth of medical costs will be contained on a sustained basis only if we prepared to ration care to those who are insured and are able and willing to pay for services . . .

Concern for fundamental values such as age, viability of an illness, and aggregate costs of treatment will inevitably shape our decisions on resource allocation. Physicians and other providers will increasingly experience tension between their historic commitment to doing all that is medically beneficial and the limitations imposed on them by increasingly stringent cost limits."

In the October issue of Science, Eleanor Chelimsky states that:

"Two other readily foreseeable effects of cost reduction on access and quality are the decrease in the amount of time physicians and surgeons can spend with patients, as well as a concomitant decrease in the number of real physician services per visit; and a corresponding increase in patient waiting time and in the number of visits required for appropriate medical care to take place."

As a country, we must decide if we are ready to ration access to health care for the American consumer. The budget and premium caps set forth in the President's plan will move us in that direction.

Implementing the President's plan will require significant new capital investment. Private estimates of new capital estimates vary all over the lot. The lowest we've seen is $30 billion over the phase-in period; the highest is $90 billion. These are hardly trivial sums. But, there will be no incentive for private investment. In a price controlled/premium capped market, companies will be severely impaired in their efforts to attract capital. Capital will be needed to organize the networks of hospitals, doctors, and other providers that are the core the new system. Capital is needed to assure that health plans have adequate reserves to cover unexpected losses and guarantee solvency. The new system will require more capital than the current system, both to cover the 37 million uninsured, and to cover the many millions of employees who will have to shift from self-insured employer plans to fully insured plans offered through the health alliance system. Most self-insured plans are not likely to have any significant reserves to offset capital requirements. These capital requirements raise great concern about the solvency of health insurers. Over the last decade, the profit margin of the health insurance industry has averaged 1.75% [see attached chart]. With that narrow margin, if the premium cap is set too low and carriers are unable to cover submitted claims, insolvencies will occur.

Mr. Chairman and Members of the Committee, it is these concerns, combined with the bill's explicit limits on plan availability that are at the heart of our concern over that part of the President's plan that establishes mandatory purchasing alliances.

QUALITY AND CONSUMER PROTECTION

Title V, Subtitle C stipulates the procedures and steps that would be followed when a claim is denied. HIAA's preliminary analysis of this title finds that it establishes a

detailed and complex regime that could substantially add to overall costs. For example, in addition to existing state regulatory bodies and the regional alliances themselves, the bill also provides for the establishment of complaint review offices in each state (Title V, Section 5202 (a)(1). Disputes reviewed under the procedures in the bill may also be reviewed by a newly created Federal Health Plan Review Board (Section 5205). For claims involving a value of $10,000 or more, a claimant may appeal the Review Board's decision in the United States court of appeals for the circuit in which the violation is alleged. In addition, the bill provides for the establishment of Early Resolution Programs which would permit a claimant to pursue non-binding mediation, binding arbitration or other forms of alternative dispute resolution as other alternatives for redress beyond those described above. It is unclear what, if any, purpose or benefit all these different forums and mechanisms would serve. It appears that all these layers will do is add unnecessary cost and confusion.

HIAA is concerned about the civil money penalties (Section 5206) allowed under the bill. In addition to attorney's fees and other "reasonable costs and expenses" stipulated in Section 5205 (g), the President's bill would also permit the Secretary of Labor to impose substantial new penalties-- $25,000 per violation where a claim was found to have been unreasonably denied, $75,000 per violation in the case of a finding of bad faith and, in the case of a finding of a pattern or practice of violation, $1,000,000 in addition to the other penalties. These penalties are both excessive and would contribute to escalating costs in the health care system and otherwise run contrary to the goal of containing costs. In addition to the civil penalties to the plans, individuals are conferred a new private right of action against a state for a state's failure to carry out its responsibilities and may recover compensatory and punitive damages. Both regional and corporate alliances are exposed to compensatory eligibility for premium discounts and cost sharing. We believe these additional damages will flow through to the health plans. In addition to the penalties being excessive the bill is unclear as to what standards would be used to assess such penalties.

The HIAA policy committees dealing with consumer protection issues have not completed their analysis of the Health Security Act so HIAA is unable to provide further detailed comments about this title of the Act at this time. However, in reviewing ERISA and various consumer protection bills over the last few years, the industry has developed several alternative proposals to address certain perceived problems under ERISA's current claims procedures. These three amendments to ERISA would: 1) shorten the claims process, 2) provide a fast, fair and user-friendly non-binding mediation process, and 3) provide for a civil penalty against plans and/or fiduciaries that engage in a "pattern or practice" of unfair claims denials. We believe these amendments (described below), together with the existing remedies in ERISA, are appropriate and should be a model for consumer protection.

EXPEDITED CLAIMS REVIEW

In general, the HIAA amendment would require that claims for medical surgical or hospital benefits be approved within 30 days of the filing completion date and that a full and fair review be provided within 30 days of the review filing date. Requests for pre-authorization would have to be approved within 30 days, and emergency preauthorization within 10 days, with the opportunity for a full and fair review of each within the same number of days as approval. We have concerns about the 24-hour expedited review process contained in the bill. The same time frames for approval and review would apply to requests for utilization review determinations and emergency utilization review determinations. The amendment also clarifies several definitions, including "preauthorization" and "utilization review determination".

NON-BINDING MEDIATION

The purpose of the amendment is to provide easy access to a fast, fair and user-friendly system to resolve claim disputes. The amendment provides that all claims for medical, surgical or hospital expenses would be eligible to go through non-binding mediation at the election of the claimant, plan or fiduciary. This would likely take care of a large percentage of cases while leaving both parties free to pursue litigation if they were not satisfied with the outcome of the mediation.

In general, mediation would be conducted by neutral facilitators identified and assigned by the Department of Labor. Mediation would be completed within 60 days from the final appointment of a facilitator with all reasonable costs divided equally between the claimant and the plan or fiduciary. All settlement offers and all documents and communications made during or generated in connection with the mediation would remain privileged and confidential and would not be admissible as evidence in any federal or state judicial proceeding unless all parties to the mediation consented in writing.

The amendment would also require every employee benefit plan to provide notice in writing to any participant or beneficiary whose claim for benefits has been denied of the availability of mediation at the election of either the claimant, the plan or the fiduciary under certain circumstances.

ADMINISTRATIVE CAUSE OF ACTION/CIVIL PENALTY

The amendment would provide for a new cause of action in addition to the removal of fiduciary remedy provided in Section 409(a) of ERISA for breach of fiduciary duty. The amendment creates a new right of civil action, solely available to the Secretary, to remove a plan administrator or other appropriately-named fiduciary, for a period of at least seven years, from a particular plan when clear and convincing evidence

establishes that this person or entity had engaged in a regular pattern or practice of repeated claims denials made without any reasonable basis, and/or repeated violation of ERISA's established claims procedures. In addition, the Secretary may seek the imposition of civil penalties against the plan administrator or appropriately-named fiduciary in an amendment not to exceed 1) 5% of the aggregate value of claims shown by the Secretary to have been denied or unlawfully delayed or 2) $100,000.

COMMUNITY RATING AND OTHER COSTS IN THE NEW SYSTEM

The administration's plan envisions the use of pure community rating to determine premiums, establishing separate rates to reflect family status. Community rating will increase premiums for younger, healthy workers and low-risk people who make healthy lifestyle choices (non-smokers, for example). Why should those who exercise regularly and don't smoke pay more for their coverage to subsidize those who smoke two packs per day? The young, who are least able to afford coverage and tend to use the system less, end up paying more in the new system. Regional alliance members will have to pay higher premiums to subsidize the additional costs of:

- underpayment by the government for Medicaid eligible;
- bad debts of people who don't pay their premiums (health plans cannot drop people for non-payment of premiums under the Administration's proposal);
- people who are currently enrolled in state-operated high-risk pools;
- early retirees no longer covered by their employers' plan.

As this Committee is well aware, privately-insured patients pay higher prices in order to make up both for uncompensated care (the uninsured) and undercompensated care (Medicare and Medicaid). Universal coverage will all but eliminate uncompensated care, but the Administration's proposed method of financing its proposal will make Medicare underpayment much worse than it is today. We see no evidence that this effect has been taken into account in the Administration's estimates of likely premiums under its plan.

The HIAA has proposed specific means by which a reformed health care system can contain costs. In its Vision for Reform, the HIAA embraced seven mechanisms to help contain costs. We believe these mechanisms are basic to reform:

- increased activity to combat fraud and abuse
- administrative simplification
- control of malpractice costs via medical liability reform
- increased reliance on managed care
- emphasis on personal responsibility and incentives for health lifestyles
- emphasis on prevention
- better access to management information

FRAUD AND ABUSE

We believe that the savings from anti-fraud activities are significant and warrant the insurance industry's continued vigilance. Each year we lose 10 percent of our total health care expenditures to fraud and abuse. That translates into an annual loss of nearly $80 billion. If we stopped payment on $80 billion in fraud, we could provide more than $2,000 in health insurance to every American who currently has no coverage.

A recent survey on anti-fraud activities conducted by the HIAA revealed that the number of fraud cases investigated by health insurance companies increased by more than 75 percent in the last two years. During the same period, insurers reported a 150 percent increase in net savings from fraud investigations. For every dollar insurers spent in anti-fraud programs, they saved nine dollars. Two thirds of the reported savings from anti-fraud activities came as a result of detecting fraudulent cases before any payment is made.

HIAA believes that President Clinton's plan to combat fraud and abuse in health care will assist insurers in investigating and prosecuting fraud cases. In particular, the strengthening of federal penalties for those convicted of fraud, anti-fraud standards for electronic media claims, and increased government funding for anti-fraud enforcement will help insurers. In addition, the HIAA would like to see broad civil immunity that would enable insurers to share information about providers suspected of fraud.

ADMINISTRATIVE SIMPLIFICATION

HIAA recognizes that all administrative processes in the health care industry must be streamlined. We are committed to working with others in the industry to increase standardization. HIAA participated in, and wholeheartedly supports the recommendations of the Work Group for Electronic Data Interchange (WEDI).

We believe that electronic data interchange (EDI), commonly referred to as a "paperless claims system" can directly improve information exchange among all of the players in the health care industry. The benefits of EDI include better, more efficient communication, improved patient care, and lower administrative costs. As the insurance industry has become more sophisticated and more responsive to the marketplace, EDI usage has increased.

HIAA believes the President's plan pertaining to administrative simplification will go a long way toward reducing administrative costs. We agree with the President; our health care system is awash in a sea of paperwork. We commend the President's recommendations for the standardization of reimbursement forms, the automation of insurance transactions, and the streamlining of Medicare.

MEDICAL LIABILITY REFORM

The costs of medical liability add significantly to the nation's health care costs. Physicians pay over $5 billion in medical liability insurance premiums annually. Even more striking are the "hidden" costs associated with the practice of "defensive medicine" by providers threatened by lawsuits. A recent study found that the health care system could save $36 billion over five years by eliminating defensive medicine practices. Medical liability affects more than just providers in the health care system. Liability costs also increase the cost of pharmaceuticals and medical devices. All of these costs are passed on to consumers.

HIAA supports federal medical malpractice reforms that will reduce the incidence of medical malpractice by improving risk management, recognizing the use of national practice guidelines as a valid defense against malpractice claims, and better policing of health care delivery. The HIAA would also like to see limits on extra contractual damages.

MANAGED CARE

HIAA believes that changing the health care delivery system is fundamental to reform. The delivery of care must be substantially better organized than it is today to meet the needs of consumers and providers. We believe that managed care can be a primary vehicle for achieving sustained system-wide cost savings.

A recent GAO Report concluded that there is insufficient evidence to demonstrate that managed care controls costs. The Health Insurance Association of America has reached a different conclusion. We believe that the success of managed care in the marketplace clearly demonstrates the value of managed care. In the last decade, enrollment in network based managed care has grown from a market share of 6 percent to 42 percent. The principal reason for this growth is that employers believe that managed care can help control their health care costs.

In addition, to growing popularity, there has been research that proves cost savings. From over two decades of studies by such noted researchers as the Rand Corporation and Hal Luft, there is convincing and consistent evidence that group and staff model HMOs reduce hospital use and costs by as much as 25 percent. These studies also found that the quality of service in the HMO was equal to the traditional fee-for-service systems with which it was compared.

Managed care systems should be permitted to pay providers in such a way to encourage quality and cost effectiveness. Providers should share in the risk of the cost of providing care, and should be rewarded for the cost-effective use of medical resources. New payment systems should be developed that encourage provider

autonomy in decision making and reduce the micro-managing of providers that exists today.

Better relationships between providers and insurers will promote: enhanced financial and managerial interactions, timely and responsive service to consumers and providers, quality management programs, and fraud and abuse prevention. The emphasis that managed care places on efficiency in the health care system should be reflected in the government's promotion of Medicare and Medicaid beneficiaries' participation in managed care.

PREVENTION

Because prevention promotes health and minimizes health care costs, the HIAA regards prevention as an essential component of health care reform. We applaud the inclusion of preventive services as part of the comprehensive benefits package in the President's plan.

Although improved coverage for preventive services will likely increase immediate demand for those services, demand for more intensive services will decrease long term. HIAA believes that coverage for preventive services is a long term investment that will benefit both the health of our nation's citizens and lower overall health care costs. For example, in a 1991 report to the Committee on Ways and Means, there are findings that for children under the age of 18, the uninsured reported 46 percent more hospital days per capita than the insured. There is a clear link between coverage for preventive services and primary care and decreased use of more intensive services.

INDIVIDUAL RESPONSIBILITY

No degree of access to medical services and no advances in medical technology can substitute for healthful lifestyles. We know that smoking is one of the single most preventable causes of death in the United States today. It is estimated that smokers experience $6,239 more in expenditures on medical care over the course of a lifetime than non-smokers. Unhealthy lifestyles, violent crime, substance abuse, poor nutrition, unsafe living conditions, and the breakdown of families all contribute to health care costs.

HIAA believes that Americans must be rewarded for assuming individual responsibility for their own health. We support the use of financial incentives for individuals to engage in healthy lifestyles and are opposed to the President's proposal for pure community rating. Community rating will increase premiums for younger, healthy workers and low-risk people who make healthy lifestyle choices. Why should those who exercise regularly and don't smoke pay more for their coverage to subsidize those who smoke two packs per day?

BETTER ACCESS TO MANAGEMENT INFORMATION

Another aspect of individual responsibility is informed decision making by consumers. Consumers must be educated about how best to use the health care system, and individuals should have financial incentives to consider cost when choosing providers and using services. They must be informed decision makers. This can only be accomplished if they have access to useful information. HIAA supports the establishment of standards for the reporting of outcome and cost information. HIAA also supports the establishment of a mechanism for pooling certain cost and utilization data on a regional, state and/or national basis. Dissemination of this information will: assist health plans in controlling costs and utilization, help managed care systems produce and evaluate outcome and cost data, and help a government-authorized entity develop guidelines that ensure that providers set consistent payment levels.

The information systems required to compile this data are extensive and will require significant new capital investment. In effect, in order to save money, insurers will have to spend money. While HIAA agrees with the President's proposal to enhance access to health care management information, we have serious concerns about whether, in a premium capped environment, insurers will be able to generate this significant new capital. Under the President's plan, premiums will be limited at the same time new and unpredictable demands are being made on health plans and insurers.

LONG-TERM CARE

HIAA is pleased to see that the Administration supports several provisions which would clarify the tax treatment of private long-term care insurance. These changes would greatly increase the affordability of these products and help millions of Americans protect themselves against catastrophic long-term care expenses.

If the Administration continues to promote the tax changes we seek, HIAA would also support the creation of federal standards for long-term care insurance products. However, such standards must not be so onerous that they prohibit all but "cadillac" policies from being sold. Equally important, consumers should be allowed to purchase federally-approved policies in all states; separate state approval should not be necessary.

We have two concerns with the newly proposed national home care program. First, a far better use of limited tax dollars would be to target care to those unable to protect themselves, and encourage those who can afford to do so, to purchase private protection. Secondly, we are concerned that the Administration will "sell" the public on this program as a down-payment toward a national solution to long-term care when even this modest home care benefit is estimated to cost $80 billion over five years. Costs alone dictate that the ultimate solution must be a public-private partnership.

TRANSITIONAL INSURANCE REGULATIONS

The transition to a new health insurance market could take several years, especially if the new market structure is as unnecessarily complex and unwieldy as the President proposes to make it. The Administration's bill specifies under Title XI, Section 11003 (a)(1) that "each health insurer that provides a group heath insurance plan may not terminate (or fail to renew) coverage for any covered employee if the employer of the employee continues the plan, except in the case of- (A) non-payment of required premiums, (B) fraud, or (C) misrepresentation of a material fact relating to an application for coverage or claim for benefit." An identical prohibition is also set forth in the bill for individual health insurance plans.

We would oppose any attempt to prohibit insurers from withdrawing entirely from the health insurance business or any significant part of it, such as the individual market or the small group market. In a free country, government should not coerce any corporation or person to continue in any particular line of business.

During the transition the Secretary of HHS is authorized to set up a National Transitional Health Insurance Risk Pool funded by premiums and assessments against all insurers based on market share in the health insurance market. This constitutes yet another cost to insurers.

However, HIAA would support some of the proposed rules. In fact, they closely parallel insurance reforms we have been promoting at the state level for several years. I refer here to such requirements as guaranteed renewal of coverage, automatic acceptance of new entrants in currently covered groups, and portability improvements which prohibit exclusion of coverage for pre-existing conditions when previously insured people change jobs or their employers change carriers. These reforms can be implemented very quickly, and do not require a new bureaucratic structure the President proposes.

Other proposed transition rules present severe difficulties for insurers. The rules establish de facto premium caps by giving states the right to approve or disapprove rate increases as specified in Title XI, Section 11004. For reasons explained earlier in greater detail, we oppose limiting insurers' ability to charge rates sufficient to cover the real costs of serving their enrollees.

There are also administrative problems with the proposed interim rating structure. It differs significantly from the rating reforms that have been enacted in more than half the states in the past three years and will therefore require significant time and administrative effort on the part of both states and carriers to implement, all for a scheme that would remain in place for a year or two.

In conclusion, I want to again emphasize that we support more of the President's plan than we oppose. We want to be a responsible participant in the national health care

debate and want to work with the Administration and Congress to develop national reform which achieves universal coverage, promotes individual responsibility and cost containment, preserves choice and maintains the quality of our health care system. During this discussion, we must remember that our health care system has many excellent features and we should build on them.

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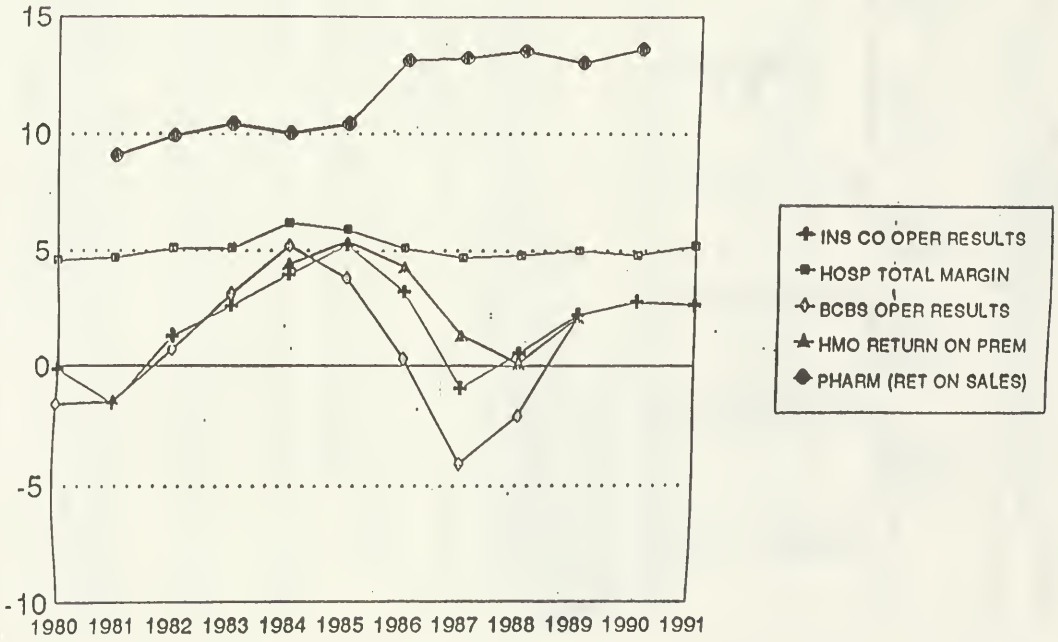
A Budget by Any Other Name: A Before-and-After Comparison

Feature	Working Group Draft*	Health Security Act
Draft uses term "National Health Care Budget"	Yes p. 93	No
Act sets annual rate-of-increase limits for premiums	Yes p. 94	Yes §6001 (a)
National Health Board (NHB) sets per capita premium target for each regional alliance (RA)	Yes p. 95	Yes §6003
Health plans bid and negotiate with alliances, which report final bids to NHB	Yes p. 95	Yes §6004 (a,b)
Alliance's weighted average premium must not exceed target	Yes p. 95	Yes §6004 (c,d)
If exceeded, NHB/RA reduce payments to plan whose premiums are over target	Yes p. 96	Yes §6011
Plans, in turn, reduce payments to providers	Yes p. 96	Yes §6012

* Page numbers are for the 9-7-93 Working Group Draft, the 239-page, 8 1/2" x 11" version, rather than the published book version.

PROFITABILITY OF SELECTED SECTORS IN THE HEALTH CARE AND HEALTH INSURANCE INDUSTRIES
1980-1991



TRENDS IN PROFITABILITY FOR SELECTED SECTORS IN THE HEALTH CARE AND HEALTH INSURANCE INDUSTRIES, 1980–1991

Year	(1) Insurance Company Operating Results (% of Prem)	(2) Hospital Total Revenue Margin (% of Tot Rev)	(3) Blue Cross Blue Shield Operating Results (% of NSR)	(4) HMO Return on Premium (Net Gain as % of Earned Prem)	(5) Pharmaceutical Manufacturers Return on Sales (Median %)
1980	(0.2)	4.6	(1.6)		
1981	(1.6)	4.7	(1.5)		9.1
1982	1.3	5.1	0.7		9.9
1983	2.6	5.1	3.1		10.4
1984	4.0	6.2	5.2	4.4	10.0
1985	5.3	5.9	3.8	5.4	10.4
1986	3.2	5.1	0.3	4.3	13.1
1987	(0.9)	4.7	(4.1)	1.3	13.2
1988	0.5	4.8	(2.1)	0.1	13.5
1989	2.2	5.0	2.1	2.1	13.0
1990	2.8	4.8			13.6
1991	2.6	5.2			

(1) HIAA survey of its top 20 members.
(2) AHA Hospital Panel Survey.
(3) Blue Cross Blue Shield net subscription revenue.
(4) McKinsey & Company, Health Care Payor Annual.
(5) Fortune Magazine, various issues.

HIAA
Health Insurance Association of America

November 3, 1993

Budget Development and Enforcement (Premium Caps) For Regional Health Alliances in President Clinton's Proposed Health Security Act

1. The National Health Board (NHB) determines a "national per capita baseline premium target" for 1994, 1995 and 1996 by adjusting and trending forward actual 1993 expenditures for items and services included in the national benefit package. (§6002)

> The legislation specifies in considerable detail the adjustments that are to be made to arrive at a fair representation of per capita spending for alliance-eligible individuals. Whether sufficient data exist to make these adjustments is another question entirely.

2a. By January 1, 1995, the NHB determines a "regional alliance per capita premium target" for 1996. (§6003(a))

> The alliance-specific targets are based on the "national per capita baseline premium target," adjusted to reflect regional differences in health care expenditures, percent of population un- and under-insured, and use of academic health centers.

2b. "Regional alliance per capita premium targets" for subsequent years are established by the NHB by March 1 of the previous year. (§6003(b))

After 1996, the new target equals the previous year's target times the "regional alliance inflation factor," also set by the NHB under §6001(a).

The "regional alliance inflation factor" equals a "general health care inflation factor" specified in the legislation (§6001(a)(3)), adjusted to take into account any material changes in the demographic and socio-economic characteristics of a particular alliance's population. (§6001(a)(2))

The factor may be reduced if the alliance exceeded its target in previous years. (§6001(d)) (See item 10, below.)

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3. By April 1 each year, the regional alliance sends to prospective health plans NHB-specified information "necessary to enable a plan to estimate, based upon an accepted bid, the amounts payable" to the plan (i.e., actual revenue the plan will receive). (§1341(a))

> Alliances must disclose to prospective bidders the "regional alliance inflation factor" (§1341(a)(2)(D)), but may choose whether or not to disclose the actual per capita premium target (§6004(a)(1)(B)).

4. Bids from health plans for 1996 are due to the regional alliance on or before July 1, 1995. For subsequent years, bids are due August 1 of the previous year. In submitting bids, plans must agree to accept any premium reduction that may be imposed under §6011 (see item 7 below). (§6004(a))

5. If the state's plan permits it, alliances negotiate with health plans over premiums to be charged. After negotiations, health plans may submit new, lower bids. (§6004(a)(2))

   Alliances are generally required to "negotiate with any willing State-certified health plan to enter into a contract" (§1321(a)(1)) but are not required to offer a contract if the plan's "proposed premium exceeds 120 percent of the weighted-average premium within the alliance" (§1321(b)).

6. By September 1, the alliance submits health plans' final bids to the NHB, along with information necessary to enable the NHB to estimate probable enrollment in each plan. (§6004(b))

7. The NHB determines a "weighted average accepted bid" (WAAB) for each alliance (§6004(c)), and compares it with the per capita premium target for that alliance.

   If the WAAB exceeds an alliance's target, the NHB notifies the alliance on or before October 1. The NHB also notifies both the alliance and each "noncomplying plan" (i.e., plan whose final bid exceeds the target) of the "plan payment reduction" (i.e., the amount by which payment to the plan will be reduced below the plan's bid). (§6004(d))

   > After the first year, whether a plan is "noncomplying" is determined by comparing the plan's bid, not with the alliance's target premium, but with a plan-specific "maximum complying bid," which equals the previous year's premium for that plan, less any plan payment reduction for that year, plus the dollar amount (not percentage) by which this year's alliance per capita premium target exceeds last year's target or WAAB, whichever is less. (§6011(d))

7. (con't)

Details of how the NHB will calculate the actual reduction for each noncomplying plan are specified in §6011(c). The reductions guarantee that the new WAAB for the alliance, after implementation of the reductions, will equal the target (unless actual plan enrollment differs from pre-year estimates). The regional alliances implement the reductions when paying health plans under §1351.

8. Each "noncomplying" health plan passes on the plan payment reduction to its providers, both participating and non-participating. The method for calculating the amount of the reduction is specified in the legislation and by the NHB and cannot be changed by the health plan. Providers must accept the reduction and cannot charge patients more because of it. (§6012)

9. The alliance publishes the final information about premiums for each of its health plans, and other required information, and holds an open enrollment period during which individuals (family heads) choose which plan they wish to enroll in. Enrollment is effective January 1.

10. Once the final enrollment in each health plan is known, the alliance reports this information to the NHB, which calculates the "actual weighted average accepted bid" for the alliance for that year and compares it to the alliance's per capita premium target. (§6001(d))

If the actual WAAB exceeds the alliance's target, the "regional alliance inflation factor" for that alliance for the two succeeding years is reduced to make up the overage. (§6001(d))

Mr. KLINK. I guess I will start with you, Mr. Freeman. You mention in your statement that Health Alliances are untested, but, in fact, we have one model, which is the Federal Employee Health Benefit Plan, which we are all intimately familiar with here on the Hill.

And we hear from a lot of people across the country, you know, Why can't we have the same kind of care you all have down in Washington, DC, like we have something very special. But the fact of the matter is that that does work here.

How would you—I mean you must admit that this plan has worked fairly well, has it not?

Mr. FREEMAN. I think that that plan works fairly well. It differs, however, in my opinion, from a mandatory purchasing alliance in that companies have the option of participating in that. Granted they can choose to or not to be a part of that. However, we have opportunities in other areas. It seems to me one of the biggest problems that we have with purchasing alliances is that they are extraordinarily bureaucratic in nature and you have government getting involved in the business of providing health care by fiat.

I guess I relate mostly to my personal experience in Ohio, and I guess what I have said over and over again is that I am not so concerned about what happens here at the Federal level as I am concerned about what happens when this becomes implemented at the State level, because a lot of the—sir?

Mr. KLINK. I was just going to say that the plan here is not bureaucratic. It is very simple. You have a number of choices that you make, just as you would with the plan that the President's laid out.

You seem to be saying that once the idea of alliances is taken from Capitol Hill out to middle America and the rest of the country it is going to change. I don't understand your assumption.

Mr. FREEMAN. I guess I have difficulty responding to that because we don't participate in the Federal Health Plan and I am not fully aware of all of its implications.

Mr. KLINK. We understand that. It is a plan that works. There is not a bureaucracy to it. You come in. You make your choices. It is bid on. I mean, in essence, what people across this country have been saying that they want is the same kind of choice that we have here, and that is essentially the way—Mr. Berumen, I can see you chomping at the mike there. Go ahead.

Mr. BERUMEN. Yes. I think it is a very good plan. I don't know a great deal about it but I know something about it. However, the employer—that is to say, the government—chose that plan on behalf of its employee population. That is a fundamental distinction between the mandatory purchasing pool and the Federal Employees' Plan.

Moreover, the range of choices are selected to suit particular needs there, and you have many choices under the Federal plan which I would submit would not be available to you under a mandatory purchasing pool because capital would be insufficient.

Many carriers, most particularly when you take community rating, pure community rating, price controls and mandatory purchasing pools together, lots of players aren't going to be at the table. They are going to have very few players, and I would submit to you that that would also occur with the Federal employees' program if

that were to participate in the mandatory exclusive purchasing pool.

So I think it is distinguishable, but it is a very fine program for what it is intended to do today under a voluntary system where the employer—that is to say, the government—has made the choice.

Mr. KLINK. Well, let's stay on this subject because I mean you all took a shot at the idea of the Alliances. I think that was something that you all were against.

How do we get our community rating if we don't do it regionally? Are you looking at one huge national umbrella, Ms. Fox?

Ms. FOX. We think that when you look at the Alliances we agree that community rating, at least with some demographic adjustments, is the right way to go. When you look at what the Clinton Alliances do, they say they pool purchasing power, but we don't think that is true. Basically what the proposal does is it says all health plans must offer the same rate to all comers. We think that is where the purchasing power is and the pool is.

We don't think you need an alliance to tell health plans they have to charge everybody the same rate. You could just enact a law that says you must do that. You don't need to construct the Health Alliance first.

Mr. KLINK. So it would be a national—I mean you would see community standards being a national standard rather than a regional standard, or State by State. What would be your population base for the community standard?

Ms. FOX. We think it needs to be adjusted for geographic areas. You would basically set the lot here in Washington saying that all health plans have to rate a certain way, but that would be done at the local level.

So, for example, in Pennsylvania you might have a few different geographic areas, but health plans, if you had five or six health plans in a certain area, each health plan would have to offer an average rate, their own average rate, to all residents in that area.

Mr. KLINK. How do we set that? How do we establish—if we don't have an alliance, a regional alliance to use as a guidepost, I mean we just—your explanation, and I don't mean to—I am certainly not picking on you, but it seems to be a little nebulous.

Ms. FOX. Okay. Well, I will be real specific then. Basically community rating means that every health plan offer their average rate. So, if I am in New York City, for example, all health plans that serve New York City give everybody one rate. So if I am Blue Cross, I charge $150 per person. If I am Aetna, I charge $170 per person. But it is their average rate.

You don't need a Health Alliance to tell health plans they have to offer the same rate to all comers. You could just say—in fact, some States are beginning to do this—tell health plans they have to charge a single rate.

Mr. KLINK. Well, see the problem that we have with that is that how I understand this cherry picking goes on.

Ms. FOX. No. What happens——

Mr. KLINK. How would we have an assurance that that won't occur?

Ms. FOX. We are very concerned about cherry picking, let me assure you. The way cherry picking happens is that some health

plans say I only want to take healthy people and not sick people. Or I only want healthy people and I am going to give them discount rates, and if you are sick I am going to surcharge you.

When you tell people they have to charge everybody the same rate, you can't have cherry picking because anybody who comes to my door I offer the same exact rate—young, old, healthy or sick—if the rule is pure community rating.

Mr. KLINK. So you could have selective marketing? I mean market only in certain areas?

Ms. FOX. We think that is a concern. We don't want to have people selectively marketing. What we would propose there is have the State Insurance Commissioner or some other State body say, here are the health plans that provide coverage to every resident. Here are their names, and here is their price, and here are outcomes measures, so that you would prevent, again, selective marketing.

That is basically the way we understand the Clinton plan would work. We don't think you need a Health Alliance to do that. We think there are other ways to assure compliance.

Mr. KLINK. Mrs. Roukema?

Mrs. ROUKEMA. This is an intriguing line of questioning.

Thank you very much. In fact, New Jersey, and I am not an authority on the New Jersey reforms, but it is based on a community rating system such as you have outlined. But I will go no farther than that.

Let me attack some of the same questions from maybe a little different perspective. First, Mr. Berumen, I believe you said that there were three elements that you were opposed to but I only heard two. Maybe I missed something. One was the mandatory purchasing alliances. Two was the premium caps——

Mr. BERUMEN. By first order.

Mrs. ROUKEMA. What was the third?

Mr. BERUMEN. Price controls. Pure community rating, as opposed to the modified community rating.

Mrs. ROUKEMA. Oh. It was community rating? I missed that. You are opposed to——

Mr. BERUMEN. Pure community rating.

Mrs. ROUKEMA. What is your definition of—I mean what is the kind of community rating——

Mr. BERUMEN. You charge any individual for the same plan the same rate, basically, and you make no distinction on the basis of—I mean in its purest form, on the basis of geography, on the basis of industry, on the basis of age, on the basis of sex.

We believe there ought to be some modifications to this to allow for distinctions.

Mrs. ROUKEMA. Tell me, either you or someone else, or both, both you and someone else on the panel, how that would square with universality and the reforms concerning cherry picking, the affordability questions that Mr. Freeman pointed out, and the elimination of cancellation for prior conditions.

I mean these are reforms that I think everybody has recognized. And I don't want to be harsh on your industry because I consider myself a friend of yours. But in truth, it is the practices of the insurance industry that have exacerbated the health care crisis, in

my opinion, perhaps more than the inflation increased costs. Among the general public I am talking about now.

You know, because that is what people are really anxious about. The fear of losing their jobs, losing their insurance or some serious illness in the family causing the elimination of health insurance. So—yes, Mr. Freeman?

It seems contradictory here. I don't know how you get the reforms and still not go along with a community rating system.

Mr. FREEMAN. The industry has for quite a great deal of time been very involved in trying to get insurance reforms, particularly in the small group environment. Beginning in 1990, the Association began to go to the States with a set of insurance reforms, including most of those, if not all, in the Clinton package. And part of that package was a scheme of premium limitations, which would prevent carriers from either overpricing or underpricing based on essentially margins around an average rate similar to what we would call a modified community rating basis, in that kind of a definition.

What the insurance industry would like to see happen is there to be some recognition of lifestyle and things of that nature, such as—and essentially we believe it is more of a fairness issue and we don't understand why a person who is healthy, runs a lot, has a healthy lifestyle should be dumped into the same pool and pay the same rate as someone with an unhealthy lifestyle who intentionally decides to do that.

Mrs. ROUKEMA. Let me interrupt you.

Mr. FREEMAN. Sure.

Mrs. ROUKEMA. All right. No, go ahead. Finish your point.

Mr. FREEMAN. I think that there needs to be, and the Association already has reform programs in place in almost 40 States that place limitations on premiums to eliminate this wide variance which relate primarily to carriers charging insurance risk—excuse me—experience against the groups rather than pooling it. However, we stop short of thinking that we should put everybody at the same rate.

Mrs. ROUKEMA. One of the things that I don't understand is how if you do not mandate coverage for each working individual, you don't mandate that coverage, and you don't have a community rating pool, how does the individual afford his own individual insurance? You see, I don't think they come together.

Mr. BERUMEN. Congresswoman?

Mrs. ROUKEMA. Yes, please.

Mr. BERUMEN. May I make a distinction between the community rating or modified community rating and underwriting practices? I agree that there ought to be some limit to what one can charge and the variation among groups given particular characteristics, but risks do vary. I think when we are talking about cherry picking, we are talking about such things as, for example, excluding individuals from coverage by virtue of their health status. I think there is very wide agreement across our industry and segments of our industry that that ought to be changed, or canceling people's coverage.

The reason why this exists is that if one carrier does this, then they are able to cherry pick against the rest. So, so many have to play by those rules. We would like to see those rules change.

The final point I would like to make, Congresswoman, is that the self-funded community, which again represents the majority of employers, even small employers self-fund. The government reports that about 25 percent of employers with fewer than 100 employees self-fund. They do not cherry pick. They insure—the employer insures who they employ. They are prohibited by Federal law, ADEA and ADA, to name a couple, from preventing people from having coverage or engaging in discriminatory practices.

Now, that is not to say that I don't know that there is some abuse, but I think it is pretty rare. So a very large part of the marketplace does not engage in that very activity.

Mrs. ROUKEMA. Well, I will have to go over that statement again. I am not quite sure I understand all the implications of it.

Let me just ask—I know my time is up, but I do have to ask one other question. You know, as we have gone through this, there are certain concepts that we thought we understood, and one that has become a term of art here has been managed competition. It is a definition that is applied to the so-called Cooper bill. It is a definition that is more or less applied to Senator Chafee's bill.

Where does what you are outlining here fall in the definition of the rubric of managed competition, because I don't get it? Of course, everybody has their own definition of managed competition, but could you give me some analogy here—not an analogy, but make the connection here or disassociate yourself from managed competition?

Ms. FOX. Thank you. We very much support the concepts of managed competition, and what we mean when we say that is to make the market work and to make price competition work for the first time.

Mrs. ROUKEMA. But it would include the reforms at a national level, national insurance reforms.

Ms. FOX. Definitely. First, you have to tell—in order to make the market work, you have to—there is no rules for insurers right now, and that is pretty unbelievable. States are just starting to enact it. But there are really no basic set of rules.

Insurers are now competing to get a lower price by only enrolling healthy people. You need to end that. You say insurers have to take everybody and charge rates the same exact way, therefore you can can't compete by cherry picking.

Then you have to say we have to have standardized benefit packages. Right now if you are a signal employer and you are trying to compare the price of two benefit packages, you can't make an apples to apples comparison. What we think makes sense is you have those benefit packages standardized so small employers can make comparisons.

Third, that you get some outcomes information so employers can figure out what their choices mean. Get some outcomes measures, and in addition make tax changes so that the Tax Code is only—tax deductions only allow for cost effective health plans so that you make people conscious of those cost decisions.

We think that will do two things. It makes consumers shop better on price and quality; and second, it sends a message to health plans that if you want to compete you have to compete by getting your price down and quality high.

Mrs. ROUKEMA. Thank you very much. We will be talking about this further as the issue develops.

Mr. FREEMAN. Can I make one final comment, very briefly?

Mrs. ROUKEMA. Yes.

Mr. FREEMAN. And that is, from our perspective she, I think, adequately described managed competition. But where the President's proposal stops being managed competition is when you put it into a framework of mandatory purchasing alliances where you take away my ability as a carrier to compete in that marketplace.

I deal—my company deals primarily in rural markets and we work with rural physicians and rural hospitals. In every alliance kind of scenario that we have seen being played out in the State of Ohio, which is ready to go, they have their State Health Care Board and they have penciled in their little alliances and each one of them includes a metropolitan market, including a very vast southeastern Ohio, very rural market.

And in that kind of environment we are going to have those kind of health care decisions made by a metropolitan market where there is very little similarity between them.

Mrs. ROUKEMA. And your people are going to be among the 30 percent or more who pay more?

Mr. FREEMAN. Probably.

Mr. KLINK. The gentlelady's time has expired. Since there are only several of us here, I would like to have another round of questions.

I wanted to follow up on what Mr. Freeman just said. If memory serves me correctly, and counsel says that that is her memory also, the Jackson Hole model and the Cooper bill also contained the alliances, the mandatory alliances. So this isn't something that was just inserted here on Capitol Hill for the Clinton plan. I mean the Jackson Hole model had mandatory alliances. So to does the Cooper bill.

Mr. BERUMEN. Below 100 employees.

Mr. KLINK. But they are still mandatory.

Mr. BERUMEN. They are mandatory. And you are quite right about the Jackson Hole proposal. It did have alliances as one of its concepts, although not mandatory coverage on the part of employers. That's quite right.

Mr. KLINK. Let me. I just want to go back again to—I mean let me just ask this question, and I guess I will start with Mr. Freeman. Do you find yourself in agreement with most of what Mr. Berumen and Ms. Fox are saying?

Mr. FREEMAN. On many issues, yes.

Mr. KLINK. Mr. Berumen, you find yourself—I am trying to find if there are great differences. You have all talked differently about these things. I know you all attacked the alliances, the mandatory alliances, but I want to find out if there are any glaring differences in your mind between your testimony and that of your two associates.

Mr. BERUMEN. Well, I don't see many glaring differences in the testimony. I suspect there are some differences in points of view, however, to which we have not testified. But I think the important thing from my point of view is that there is a market out there that is generally ignored and some of the trade associations are not

talking about it, and that is the self-funded marketplace. So I think that is a major difference of emphasis, not a disagreement in some of the points.

And, if I disagreed with any one thing it would be the notion of pure community rating, which I am not sure if Ms. Fox agrees with pure community rating or a modified community rating.

Mr. KLINK. We will let her answer that.

Ms. FOX. We support community rating with limited age adjustments in the small end of the market. And if you don't have those age adjustments—we think those age adjustments are important because if you don't have some age adjustments, young, healthy small employers will have to pay significantly more. So we think that that might make sense, especially in the beginning.

I think that we don't—we oppose having experience rating in the small group market, and I am not sure if the other witnesses support that. It sounded to me like they do. They would allow some health status to be factored into the determination of people's rates, and we don't think that belongs there.

Mr. KLINK. The question is, as I hear each of you say we agree with the concept of the Clinton plan and then tend, each of you, to disagree with major portions of it in following statements. What I have to ask, how could this proposal as written, and we all, I think, recognize there are going to be changes made, and I know that is why you are here, to try to influence those changes as much as you can.

But how could you create more bureaucracy, how could you create a more complex system than the current one of some 1,500 insurers, half a million separate employer-sponsored plans, medicare, medicaid, health plans sponsored by States, by local governments for their own employees, the Indian Health Service, the VA, CHAMPUS, each with a different set of rules, each with a different set of forms? I don't know how we could be much worse off than we are now.

Ms. FOX. I would like to take a shot at that. I agree 100 percent that we need reform. We are not arguing for the status quo. We think you need tough standards for health plans to operate, and if you can't meet those standards you don't belong in the business. We think that will reduce the number of health plans participating in States.

We think you need significant change. What we are talking about, we are saying we don't think you need mandatory Health Alliances. We have some differences here, but what we are saying here when we don't like mandatory Health Alliances, we are looking at every function that the Clinton administration says they want to accomplish with those mandatory Health Alliances, and what we have said in our testimony is we don't think you need those alliances to accomplish those goals.

So we want to work with you in crafting a bill that gets at those objectives, but we don't think mandatory alliances are the way to go and we want to offer you alternatives as you progress in drafting legislation.

Mr. KLINK. Believe me when I tell you, and I agree with Mrs. Roukema, I am not an enemy of the insurance industry. I know that you have a lot of problems. But I still, you know, I still don't

understand. We held, this committee held a hearing in my district and I heard a lot of the same things that you are saying. You didn't like the exemption for preexisting conditions, but you kind of had to do it because everybody else was doing it.

I don't understand why the insurance industry didn't when they had the chance to discipline themselves on many of these issues. And I also am still at a loss—maybe I am dense, but I still am at a loss to understand, after listening to all three of you, I still remain unconvinced if we don't establish these mandatory alliances, if we call upon it to be voluntary, where there is going to be any discipline in, and I still think that we risk market segmentation and selection, cherry picking, all of those, selective marketing, all of those pitfalls, and I still remain unconvinced by most of your statements.

Ms. FOX. I would like to answer that, and two things. First of all, Blue Cross/Blue Shield Plans invented community rating, invented procedures where we took all comers. What has happened today—in some States we still do that, like in Pennsylvania.

So we were taking everybody, charging average rates. What happened, when not everybody does it, when competitors are selective in who they take in and give discounts to healthy people, you create an unlevel playing field. You can't operate that way. You need a law that says everybody has to play by the same set of rules.

Mr. KLINK. Excuse me, Ms. Fox. Are you saying that Blue Cross/Blue Shield has never turned down anyone?

Ms. FOX. No, I am not saying that at all. I am saying that we started taking everybody. Some of our plans still do. In many States, we turn down people today, but it is because we couldn't sustain the practice of taking everybody when our competitors didn't. And that is why we think we need laws that require everybody to play by the same rules.

And second, we are not saying no regulation. We think the bottom line for managed competition is regulation. We think that is what the Federal Government does best, is the Federal Government should regulate it and the State Insurance Commissioners should regulate that and assure that health plans are taking all comers and charging the rates as set down in Federal statute.

So we are not saying no regulation, we are saying the State Insurance Commissioner should regulate, and you don't need a Health Alliance to set up a new regulatory mechanism because the States already have them today.

Mr. KLINK. I might tell you, Ms. Fox, you may be the first witness that I have heard since I have been here during the past year from private industry who has said that the Federal Government does a good job of regulating. But thank you for that.

Mr. Berumen, I think you had a comment.

Mr. BERUMEN. Yes. Congressman, I have. Two things: The government does a pretty good job of creating policy, and as a regulatory function. It does a pretty poor job, though, in delivering goods and delivering services for consumers. I think that is a fundamental distinction.

I believe and my company believes that we do need Federal reform, and we also need State level reform, in order to solve this problem. Unfortunately, an industry as large as ours can't self-dis-

cipline itself 100 percent, and that is where we need the government. I think that that could effect a lot of changes that would, in fact, result in many of the things, many of the objectives that the President has.

The idea of the mandatory alliance being necessary to prevent cherry picking is just not true. One could have rules which prevent one from practicing the more onerous forms of underwriting across the board, whether one was insured or self-funded, or in an HMO or in a service plan.

The idea that an exclusive alliance is necessary comes from the notion that, "Gee, if we don't have a very large group and spread all of this risk, and if we have anyone on the outside they can cherry pick against us," is just not true.

First of all, mathematicians will tell you that you probably need about 50,000 people to form a predictable group in an alliance given certain conditions, one of which is that anyone outside of the alliance and in the alliance plays by certain of the same rules. Not all the same rules, but certain of the same rules.

Moreover, there is a lot of talk about the economies of scale. That the alliances will be so much more efficient than private industry. Well, first of all, I don't think that there is much evidence that the government has been more efficient than private industry, even though I will admit to you that there are some inefficiencies in the 1,500 insurance companies and so forth.

The second thing is that mathematically you find that you get diminishing returns once you have reached an employee population of about 25,000. Very small insurance companies insure more than that.

So I think these arguments are overwrought, and I think that many of the problems associated with our industry today and health care can be reformed at a Federal and State level. But I also think we have a tendency, a remarkable tendency to ignore the underlying reasons for health care costs or insurance costs.

The raw material of health insurance, after all, is the cost of providers, hospitals and physicians. And I think the President is hoping that by creating these cartels that the insurance industry will be able to wrest a lot of control away from providers, and very frankly, I don't think the consequence will be what the American people want.

Mr. KLINK. Mr. Payne, do you have questions for our witnesses?

I would like to thank each of you for being here. You have been very patient. You have answered our questions, and we thank you for being with us.

With that, this hearing is adjourned.

[Whereupon, at 12:22 p.m., the subcommittee was recessed, to reconvene subject to the call of the Chair.]

[Additional material submitted for the record follows:]

STATEMENT OF DEANNA GELAK, PHR, MANAGER, GOVERNMENT RELATIONS, SOCIETY FOR HUMAN RESOURCE MANAGEMENT, ALEXANDRIA, VIRGINIA

The Society for Human Resource Management would like to submit testimony for the record for the most recent hearing on the President's health care security proposal, held on December 9, 1993. I understand that because of the holidays, the record my remain open until after the first of the year.

The Society for Human Resource Management [SHRM] is the leading voice of the human resource profession, representing the interests of more than 56,000 professional and student members from around the world. SHRM provides its membership with education and information services, conferences and seminars, government and media representation, and publications that equip human resource professionals to become leaders and decision makers within their organizations. The Society is a founding member and Secretariat of the World Federation of Personnel Management Associations [WFPMA] which links human resource associations in 55 nations.

Human resource professionals are uniquely suited to contribute to the health care reform debate. We are often regarded as the most important human link between an employee, the employer and the insurer. Employees often count on us to explain benefit plans and employers look to our expertise in helping to hold down health care costs. For all of the above reasons, SHRM would like its views on health care reform reflected in the record.

Thank you for your consideration, and I look forward to working with the committee as the important issue of health care is examined.

MICHAEL R. LOSEY, SPHR

The Society for Human Resource Management (SHRM) is the leading voice of the human resource profession, representing the interests of more than 56,000 professional and student members from around the world. SHRM provides its membership with ongoing government and media representation, education and information services, conferences and seminars, and publications that equip human resource professionals to become leaders and decision makers within their organizations. The Society is a founding member and Secretariat of the World Federation of Personnel Management Associations (WFPMA) which links human resource associations in 55 nations.

Undoubtedly, the issue of health care reform is one of the most important challenges facing the nation, the Congress and the human resource profession. As both consumers and purchasers of health care, the more than 56,000 members of the Society for Human Resource Management (SHRM) are confronted with the difficulty of providing health coverage to their employees while managing the escalating costs to their businesses. Therefore, SHRM is excited about the prospects for reform of our nation's health care system. However, we are equally concerned about the shape that the reform will take. As your Committee continues to refine the details of the President's "Health Security Act" (H.R. 3600) and to examine alternative health proposals, real world experiences of human resource managers in designing employee health plans will provide invaluable information. Since human resource practitioners will be responsible for implementing and integrating new health care reform requirements with existing benefits plans, SHRM is uniquely suited to provide practical insights on the effects of the proposal.

First of all, SHRM would like to commend President Clinton and the Administration for their efforts to address the critical and complex issue of health care reform. We appreciate the goals of security, simplicity, savings, choice, quality, and responsibility. However, since the devil is often in the details, we would like to offer the following specific comments on the proposal based on the framework of health care principles approved by our Board of Directors in 1992:

I. Basic Benefits Package

SHRM believes that the basic core of health care services should emphasize preventive care and commends you for including preventive care in your package. SHRM is concerned, however, that design of the basic benefits package is too generous and does not carefully consider the costs of providing these benefits.

II. Purchasing Pools

SHRM believes that small employers should be encouraged to form risk sharing groups to obtain affordable coverage. The government should provide incentives and/or sponsor public/private vehicles for risk sharing and/or insurance. While SHRM supports the creation of purchasing pools to give small businesses more bargaining power, SHRM believes more than one health alliance should be permitted in a geographic region so that employers have a choice of a purchasing agent. SHRM supports allowing multiple competing health alliances within an area and permitting smaller employers to band together to form a competing health alliance.

In addition, the Health Security Act's requirement for most employers to purchase coverage through the health alliance would negatively affect many mid-size employers who are currently self-insured. As proposed, we believe that the 5000 employee limit is far too high, affecting only a handful of employers, while disenfranchising thousands more.

III. **Corporate Alliances/ERISA**

SHRM believes that the Health Security Act would discourage employers from electing to maintain self-insured plans or negotiating directly with a health plan. Only employers with more than 5000 employees who elect to establish a corporate alliance to maintain self-insured plans would qualify for an exemption under the Employee Retirement Income Security Act (ERISA). ERISA would be amended to require corporate alliances to meet new federal guidelines. In addition, the statute would be amended to permit taxes and assessments on corporate alliances.

SHRM strongly opposes this erosion of ERISA preemption. National health care reform should include a uniform set of federal rules and regulations and should apply to those purchasing health care, rather than the wide variations existing from state to state. Rather than being reduced, we believe that preemption under ERISA should be expanded to address all health standards. Health care plans and the laws that apply to them are complex enough. Employers who want to expand regionally or nationally should not be inhibited from doing so by a maze of conflicting state requirements. Further, employers currently self insure to better manage the costs of their plans and meet their employees' needs. Under President Clinton's plan, employers would no longer have this control over the design of their plans.

IV. **State Authority**

Under the Health Security Act, ERISA would be amended to permit any state or part of a state to establish a single payer system of health care. This provision would allow the federal government to waive ERISA requirements and other rules governing corporate alliances, thereby eliminating corporate alliances in states or parts of states.

SHRM opposes health care reform provisions that would give states a "blank check" to disregard federal directives and impose their own version of health care on the employers located within their borders. Specifically, SHRM opposes granting states the authority
to establish a single-payer system of health care at the federal/state level. Such a system would eliminate the competitive forces of an employer-based system which can promote quality and reduce costs.

Under President Clinton's plan, it is likely that additional state regulations would affect employers. For instance, states could require plans to provide benefits in excess of any federal standard benefits package. Health alliances could be run by the states, and states could impose taxes on provider services which could be passed on indirectly to employers and employees.

Many SHRM members work for self-insured companies with operations in multiple states and are concerned that under the new system they will have to begin complying with a patchwork of state laws.

V. **Employee Contribution**

We strongly believe that incentives should be provided to encourage payers and patients to act as consumers in choosing health care services that are cost-effective. Deductibles, co-payments and reasonable contributions by participants should also exist to encourage individuals to make consumer-like decisions about health care. Specifically, employees should be required to make some level of copayment. This would help to prevent the utilization of health care services from rising uncontrollably as coverage expands. Therefore, the level of employee copayments and deductibles should be high enough to discourage unnecessary utilization of health services.

VI. Taxation of Benefits

The Health Security Act would permit employers to continue to deduct the cost of the basic benefits package as a business expense. The cost of additional benefits would be taxable as income to employees after a 10 year grandfather clause. Section 125 or "cafeteria" plans would be amended to exclude employee contributions for health benefits.

SHRM believes the tax structure should encourage payers and patients to act as consumers in choosing health care services that are cost effective. SHRM strongly supports the continuation of Section 125 benefit programs since they encourage employees to plan for their medical expenses.

VII. Workers' Compensation

Initially, the Health Security Act would require that workers' compensation related health care treatment be provided through the state-certified health plans. These health plans would designate a case manager to handle job-related injuries and illnesses and adopt certain treatment guidelines for handling workers' compensation cases. In addition, a new Commission would be established to study the feasibility of fully integrating the medical part of workers' compensation with the health care system and make recommendations by 1995.

SHRM is in the process of developing a position on the coordination of the workers' compensation and health care systems. However, any reform should not result in cost-shifting to the payers who reimburse the costs of care for job related injuries and illnesses. Changes should not jeopardize the existing incentives for safety nor affect the exclusive remedy. Also, any system should help employers control indemnity costs by encouraging employees' rapid return to work.

VIII. Malpractice reform

The Administration's health plan would establish a mandatory, non-binding Alternative Dispute Resolution (ADR) mechanism to settle complaints. Attorneys' fees would be limited to a maximum of 1/3 of an award and states could impose lower limits. It would also establish a pilot program of practice parameters to set guidelines for appropriate care and establish grant programs for state demonstration projects in enterprise liability. It does not, however, set any limits on punitive damages which contribute to the high costs of malpractice.

SHRM believes that reform of the medical malpractice system could contribute significantly to the reduction of health care costs. Any comprehensive health care reform proposal should improve this system to avoid wasted energy and money spent on unnecessary "defensive" medicine and litigation.

IX. Insurance Reforms

The Administration's plan would prohibit preexisting exclusions and waiting periods. Plans would not be able to terminate, restrict or limit coverage for any reason, including non-payment of premiums, and a system of community rating would also be established.

SHRM supports insurance reform provisions which address portability, risk sharing, and community ratings, particularly in the small market.

X. Employer Mandate

SHRM believes that employers should not be required to pay for a portion of their employees health premiums -- particularly not an amount as high as 80 percent as proposed by the "Health Security

Act." According to the Employee Benefit Research Institute (EBRI), would result in a net loss of 168,000 jobs. Other academics and organizations estimate an even higher number of jobs lost.

SHRM believes that the solution to the problem of the uninsured depends on the careful coordination and planning of all concerned parties. We endorse the continuation of an employer-based system. We believe that the problem of the uninsured is a societal problem and not a problem solely to be resolved by employers and other private payers. Accordingly, SHRM opposes pay or play proposals which require an employer to either provide coverage to their employees or contribute a percentage of their payroll to a
government insurance fund. SHRM strongly opposes any proposal that imposes a mandate on employers as the sole solution to health care reform.

XI. Individual Obligation

According to the Administration's proposal, it is the obligation of every individual to enroll in a health plan. Therefore, anyone who does not meet the established deadline for enrollment is automatically enrolled in a health plan when they seek medical care.

SHRM recognizes that the costs of unpaid health care for the uninsured and the underinsured result in increased health care costs to the private sector. By requiring all individuals to have health coverage, the costs to the insured of treating the uninsured would be reduced. SHRM believes that a strong disincentive should be provided to prevent individuals from postponing enrollment in a health plan.

XII. Health Plans

As we understand the "Health Security Act", every employee would have a choice of at least three health plans each with a point-of-service option.

SHRM believes that the use of managed care programs should be expanded. Managed care allows employers, providers and employees to reduce health care spending together. There are various types of managed care programs, and employers and employees could decide which type is best suited for their specific needs.

Employers of all sizes have been able to provide sound and informed choices for their employees. While the goal of presenting several options to employees is laudable, any health reform proposal should enable employers to meet the information needs of their employees without creating unnecessarily complex administration and communication requirements.

In general, while the low cost-sharing plan should indeed cost employees less than high cost-sharing plan, its pricing and the reporting of qualitative measures must still promote consumer-like behavior.

XIII. Cost/Financing

SHRM believes that health care reforms should be based on a model which has built-in incentives to balance both quality and cost-efficiencies. Any cost-containment proposal should contain measures to eliminate cost-shifting. SHRM is concerned by criticism of the Administration's financing mechanism and will evaluate the financing mechanism of any health reform proposal since inadequate funding will lead to further cost-shifting.

In conclusion, SHRM recognizes that there is no panacea for health care reform. It is a system that requires comprehensive

reform and the compromise of all parties involved. Accordingly, we urge you to consider the concerns of human resource experts throughout the next several months as you debate the details of President Clinton's proposal and seek to understand the real world effects of this and other health-care reform proposals. We would be happy to work with you to provide information on our members real life experiences with the health care system. I hope that you will contact the Government and Public Affairs Office at (703) 548-3440, ext. 3608 if we can assist you as you continue to consider the important issue of health care reform.

The National Association of Children's Hospitals and Related Institutions, Inc.

Statement for the Record
Subcommittee on Labor-Management Relations
Committee on Education and Labor
U.S. House of Representatives

Mr. Chairman, I am Lawrence A. McAndrews, President and Chief Executive Officer of the National Association of Children's Hospitals and Related Institutions -- NACHRI. I appreciate the opportunity to submit for the record of the subcommittee's hearings on health care reform the attached statement.

NACHRI represents more than 130 institutions in the United States and Canada, including: free-standing acute care children's hospitals such as my own, pediatric departments of major medical centers, and specialty children's hospitals devoted to specific services such as rehabilitative care for children.

Children's hospitals play an essential role in the delivery of care to the most vulnerable of children -- the sickest, the poorest, and those with the most specialized care needs. For example, on average, children's hospitals devote nearly one-third of their beds to children in intensive care units, more than 44 percent of their inpatient care to children who depend on Medicaid, and more than 70 percent of their care to children with a chronic or congenital condition.

Children's hospitals are essential to children's access to both the basic and the specialized care they need today. They also are essential to children's access to care tomorrow, because they are devoted to training the next generation of pediatric health care professionals, and they are engaged in ground-breaking medical research for children. For example, children's hospitals and pediatric departments of major university medical centers represent only seven percent of all hospitals, but they train the majority of pediatricians and the vast majority of pediatric subspecialists.

Because of their missions of clinical care, education, and research devoted to children, children's hospitals bring two fundamental observations to the debate over national health care reform:

- First, children desperately need national comprehensive health care reform, because children are at the very frontlines of erosion in private health care coverage and change in the health care marketplace.

- Second, health care reform must be tailored to fit children's different health care needs, because when it comes to children's health care, one size won't fit all.

I would like to discuss each of these observations in more detail and then conclude my testimony with a discussion of our views on the major health care reform legislation pending before Congress.

Children Need Comprehensive Health Care Reform

Children desperately need comprehensive health care reform, because they are at the frontlines of the erosion in commercial health care coverage. Studies show that in the struggle to cope with rising health insurance costs, both employers and individuals often draw the line first at paying for dependent coverage. Loss of dependent coverage, coupled with pre-existing condition exclusions and life-time maximums on coverage, hits children hard, especially those requiring the care of a children's hospital.

As a consequence, more than one in three children in the United States now depends either on Medicaid, which is a critical but often underfinanced poverty program, or on charity to pay for their health care. That proportion continues to grow. In other words, in 1992, 13.5 million children depended upon Medicaid and another 9.5 million children were uninsured, representing 35 percent of the nation's 65.1 million children, according to estimates based on U.S. Census Bureau data.

Medicaid has become the nation's safety net for children's access to health care -- particularly children with special care needs. The emergence of Medicaid as the children's safety net has been a tremendously important development. The children's hospitals and the families they serve are deeply grateful to the members of this subcommittee who supported efforts for so many years to enable Medicaid to cover more and more children left without private insurance. But we know that Medicaid often has been challenged to fulfill its promise to children because of inadequate resources for eligibility, outreach, and payment. We also know that many states are now stretched to the financial limit by their Medicaid programs. In today's fiscal and political climate, Medicaid and charity are an imperfect and ultimately financially unsustainable safety net for children.

Children also are at the frontlines of change in the health care delivery market place, and the pace of that change is about to step up substantially because of Medicaid. In health care marketplaces around the country, we are seeing a significant new surge in the conversion of traditional indemnity coverage for fee-for-service health care into managed care coverage, including enrollment in risk bearing, capitated health plans.

Now, many state Medicaid programs are contemplating what the State of Tennessee has just received federal permission to do -- enroll all Medicaid recipients into capitated managed care plans in a matter of only months. Since half of all Medicaid recipients are

children, and 70 percent are mothers or children, the conversion of Medicaid fee-for-service to capitated managed care will be especially significant for children and their ability to receive the care they need. If done right, managed care holds great potential for children by creating incentives for them to receive the health services when they can benefit most from them. But make no mistake about it, the statewide Medicaid managed care experiments upon which states are embarking are experiments that affect primarily children.

That is why we believe health care reform is so important for children, both to give all children coverage of uniform health care benefits and to influence the way in which health care is financed so that universal coverage translates into access to appropriate care.

Health Care Reform Should Be Tailored to Fit Children's Needs

Many Members of Congress have visited a children's hospital -- as a parent, family member, or friend of a patient or as a guest of the hospital. You know that our institutions look and feel very different from other hospitals. You know that the care givers who work with our institutions often have different training and different experience than care givers in other hospitals have.

All of these differences that define the character of a children's hospital might be summed up by the slogan: "When it comes to children, one size won't fit all. We must tailor health care to fit their needs." This slogan may have a simplistic ring to it, but it has profound implications for the way we deliver care to children. Just this past summer, the Institute of Medicine issued a major report on emergency care for children that concluded our health care delivery system is failing to meet the needs of children who suffer from injury or trauma, because all too often our emergency and trauma care services are designed to fit the needs of adults or "average" people, not the needs of children.

For example, because children have smaller veins that often are not receptive to emergency injection of fluids, such injections may need to be made directly into their bone marrow. And because children's blood supply is smaller, injured children frequently experience a much faster drop in blood pressure. As a consequence of emergency services not being designed to fit these kinds of different needs, children's survival and recovery from injury or trauma can suffer.

The children's hospitals believe it is equally true that when it comes to health care reform, one size won't fit all. We must tailor the requirements of reform itself to fit children's needs. I would like to give you examples of what I mean by focusing on four areas of consensus on health care reform between leaders in

both political parties. These areas of consensus involve commitments to uniform benefits, managed care, cost containment, and Medicaid's replacement.

Uniform Benefits Leaders in both political parties have advocated that the federal government establish, by act of Congress or independent commission, a uniform benefit package for all Americans, with special emphasis on primary and preventive care. That is a very important, bipartisan commitment, which is sure to benefit children, for whom preventive and primary care often is the least expensive and promises the best financial returns in terms of well-being and future productivity. However, as experts in the care of children with special care needs, we know that it is equally important to focus attention on how the benefits will cover the needs of the child with a chronic or congenital condition, such as cerebral palsy.

For example, if standard benefits limit coverage for rehabilitation to treatment of "illness" or "injury," they could be subject to the risk of interpretation that they do not cover congenital conditions, which are the result of neither illness nor injury. Or a limit on coverage to treatment that results in "improvement" of function could deny coverage of therapies that would enable children with special needs to "maintain" a level of function, allowing them to attend school or live at home. Or it could deny coverage of therapies prior to surgery that could be essential to a successful outcome. In addition, an "improvement" standard may not recognize the need for "habilitation" to help children attain function for the first time.

That is why children's hospitals say that the uniform benefits in health reform must be tailored to fit all children.

Managed Care Leaders in both political parties believe that in order to restructure the way in which we deliver care, we need to promote more enrollment of individuals and families into risk-bearing, capitated health plans. Whether they call it managed competition, managed collaboration, or something else, both Democratic and Republican leaders on health care reform believe we should give health plans an incentive to manage the care needs of individuals cost-effectively by giving them a single, fixed per capita payment -- adjusted for the risk associated with the individual's health needs -- for every individual enrolled.

Managed care has great promise to meet the needs of children if financial incentives facilitate their access to primary and preventive care. Indeed, through the provision of multi-disciplinary care involving the family, many children's hospitals have pioneered in managed care in the best sense of the word by trying to make sure the child receives the most appropriate care, including inpatient care, only when it is truly necessary.

But if managed care is purely cost-driven, it can have the opposite effect for children, denying them access to appropriate

care instead of assuring it. The fact is that many of the protections essential to managed care -- risk adjustment, public cost reporting, measures of quality and outcomes -- have not been developed for children. At the same time, because so few children comparatively require hospitalization, they are more dependent than adults on having access to regionalized centers of care. These are providers, both institution and individual, who see a large enough volume of pediatric patients with specialized conditions that they are able to achieve and maintain both expertise and efficiency in pediatric care.

Such institutions -- children's hospitals -- also carry the added costs of their commitments to serving a disproportionate share of low income patients, training the future generation of peditaric health care professionals, conducting pediatric medical research, and caring for the sickest of patients. If driven only by costs and lacking adequate tools for risk adjustment or measures of quality for children, managed care plans often will refer only the sickest and most expensive patients to children's hospitals and other pediatric specialized facilities, making them financially unsustainable. Or, to gain competitive advantage, managed care plans will seek to prevent children's hospitals from contracting with multiple plans, which often is essential for the hospital to serve a large enough population of children to sustain its specialized services. These are not concerns borne out of speculation; these are the real life experiences of children's hospitals seeking to fulfill their missions in managed care driven markets today.

That is why children's hospitals believe it is so important that health care reform built upon capitated managed care must manage the competitive market to ensure children's access to the care they need. It is important to ensure that health plans:

- provide access to pediatric specialists and subspecialists, so that when a child needs a cardiologist or pulmonolgist or other subspecialist, it is one who is trained in pediatric cardiology or pediatric pulmonology;
- allow pediatric providers to contract with multiple plans;
- avoid unnecessary duplication of regionalized services;
- contract with and refer patients to hospitals that have demonstrated themselves to be "essential" to the children of low income and medically underserved communties;
- contract with and refer patients to academic health centers and other providers specialized in the treatment of rare and unusual conditions, including pediatric specialized providers;
- separate the financing of graduate medical education from patient care reimbursement; and

- require health plans, in accounting to the public for the costs and quality of care, consumer satisfaction, and health status of the population served, to report in terms that are specific to children and their needs.

Cost Containment There has been much disagreement both between Democrats and Republicans, and within their respective parties, about whether and how to cap the growth in health care spending nationwide, the growth in commercial insurance premiums, or the amount of reimbursement given to individual providers.

However, as institutions that devote a major portion of care to children assisted by Medicaid, children's hospitals are struck by the fact that leaders in both political parties strongly agree on capping the growth in Medicaid, at least at a per capita level. That is the equivalent of a de facto spending cap on health care spending for children. Therefore, even if they may not support the principle of government caps on health care spending, children's hospitals already live with the reality of caps on Medicaid. We believe it is imperative to talk about the need for cost containment strategies to be adjusted to fit children's needs.

Let me explain why this is so important. Children have different health care resource requirements than adults have, and the patients of children's hospitals have different resource requirements than children receiving care in general hospitals. For every hour in the hospital, a child on average requires 31 percent more routine nursing care than an adult; a child younger than two requires 45 percent more care than an adult. The patients of children's hospitals require even more intensive care, because they are younger, sicker, and more likely to have a chronic or congenital condition than the pediatric patients of general hospitals. Since nursing care is a major portion of the expense of hospitalization, these differences can have significant implications for the resource requirements of children.

Too often, strategies to cap health care spending fail to take into account these differences. We see proposals to cap national health care spending based on an extrapolation of historical rates of health care expenditures, in which the costs of children's and adults' care have been averaged together. In addition, children have been disadvantaged in historical spending -- because they have been disproportionately poor, dependent upon Medicaid which has inadequately reimbursed care, and dependent upon primary and preventive care, which indemnity plans traditionally did not cover. Caps on health care spending will not make sense for children if they are based on historical spending, instead of an assessment of children's real health care needs.

Most advocates of capitated payment for health care have recognized the importance of risk adjustment -- adjustment of capitation for the risk of higher or lower costs of care associated with an individual. Without such risk adjustment, a health plan or health care provider who cares for a population that is

disproportionately sicker would be at financial risk. This is exactly what a children's hospital is -- an institution which specializes in caring for higher risk children with the most complex care needs. However, experts in capitation and risk adjustment have testified before Congress that risk adjustments specific to the needs of children -- particularly children with special care needs -- simply do not exist, and will take years to develop. That is why children's hospitals believe we must begin now to invest in risk adjusters for children, even before embarking on health care reform. And if reform is implemented before pediatric risk adjusters are developed, interim measures, such as mandatory reinsurance for a wide range of children's chronic and congenital conditions or exclusion of these cases from capitation, will be necessary.

Children's hospitals have learned the necessity of adjusting cost containment strategies to children's needs through years of living with state Medicaid programs and private payers, which have adopted the Medicare diagnosis related groups (DRG) payment methodology, even though it was not designed for a pediatric population. According to financial experts whom the federal government often has used for payment policy analysis, no children's hospital could survive financially if it were subject to the Medicare payment system unadjusted for the needs of children in general and the needs of children's hospitals' patients in particular.

That is why children's hospitals believe that in health care reform, cost containment strategies must be tailored to fit children's needs.

Medicaid According to opinion surveys, most people think Medicaid is either a welfare program or Medicare. But to children's hospitals, Medicaid represents the nation's largest and most important child health program. No single program, public or private, affects more children nationwide or more children in children's hospitals. Therefore, it is especially important that great care be given to how health care reform transforms Medicaid.

Let me give you an example. Many leaders in both political parties have called for the elimination of Medicaid disproportionate share payment adjustments -- extra payments given to hospitals that serve a disproportionate share of low income patients. They contend that such disproportionate share payments are only needed to pay for the costs of care of charity patients. With the achievement of universal coverage, they believe, such payments no longer will be necessary.

However, to children's hospitals, disproportionate share payments represent something entirely different. In most states, including Missouri, the Medicaid program makes disproportionate share payment adjustments because the base Medicaid rate is substantially inadequate to cover the costs of care. These payment adjustments have been critical to the ability of children's

hospitals to play such an important role in providing access to care for children of low income families.

If Medicaid financing continues at historically inadequate levels, exacerbated by the elimination of disproportionate share payments, health plans and communities with larger numbers of low income people will be particularly hard hit, as will the institutions devoted to serving them. This will be doubly true for institutions such as children's hospitals, which serve large numbers of both low income and high risk patients.

That is why children's hospitals say that Medicaid's replacement in health care reform needs to be tailored to fit children's needs.

NACHRI's Comments on Health Care Reform Proposals

In recent years, many Members of Congress have worked to strengthen Medicaid so that it could become a true safety net for children and to move the Congress toward the achievement of national health care reform. The children's hospitals and the children and families we serve are deeply in their debt.

We also recognize that despite the valiant efforts of many, no one political leader has done more than President Clinton to move comprehensive health care reform to the top of the nation's political agenda. We strongly support his leadership, and we strongly support many of the principles we believe are fundamental to his health care reform initiative: universal coverage, comprehensive benefits, employer-based coverage, assurance of choice among health plans, recognition of the roles of essential providers of care to low income patients and academic health centers treating rare conditions, separating the financing of graduate medical education from patient care reimbursement, sustaining Medicaid eligible children's access to medically necessary care, and more.

A number of other important proposals also attempt to address these basic principles. But for several reasons, NACHRI has thus far not endorsed in detail any individual legislative proposal. For one thing, the legislative language on all of the proposals still is only just becoming available. For another, as the committee members well appreciate, these proposals are enormous in their scope and implications for health care delivery, requiring much review just to begin to understand them, much less endorse them. For a third, we believe many of the proposals on the table could benefit from learning from one another. We believe the President's plan is a good place from which to build a coalition for health care reform, both in terms of his fundamental commitments and in terms of his willingness to consider changes in the details.

But most fundamentally, children's hospitals believe that we need to balance continually our commitment to advocating for comprehensive reform with our commitment to making sure that all children have access to the kinds of services they specifically need. Our institutions and the care givers we house have devoted professional and personal lifetimes to the details of children's health care needs. It has become a cliche in health care reform to say that the "devil is in the details," but it is nonetheless an absolute necessity in children's health care -- whether it involves making a diagnosis, prescribing a treatment, or assessing health care reform.

Children's hospitals welcome the opportunity to work with this subcommittee to advance health care reform for all Americans and to make sure it fits the needs of all Americans, including our children.

Thank you for your consideration of our statement submitted for the subcommittee's hearing record.

Summary

Children's hospitals play essential roles in caring for children who are the sickest, poorest, and in need of the most specialized services. They also are important educators of pediatric health care professionals and centers of pediatric medical research. Because of these roles, children's hospitals bring two basic observations to the health care reform debate:

First, children desperately need comprehensive health care reform, because children are at the frontlines of the erosion in private health care coverage and rapid change in the health care delivery marketplace. One in three children now depends on either Medicaid, an underfinanced poverty program, or charity, and the proportion continues to grow. That is unsustainable.

Second, health care reform needs to be tailored to fit children's needs, because when it comes to children's health care, one size won't fit all. Uniform benefits, managed care policies, cost containment, and Medicaid's replacement should recognize children may require different services as well as health care professionals experienced in pediatric care.

Uniform Benefits While it is important to emphasize primary and preventive care in defining uniform benefits, it also is important to make sure these benefits meet the needs of children with special care requirements, such as children with chronic or congenital conditions. Even if the uniform benefit package should limit some benefits to acute and post-acute care, children with congenital or chronic diagnoses should be included.

Managed Care In promoting the reorganization of health care delivery through capitated, risk bearing managed care plans, health care reform should manage the competitive market to ensure children will have access to pediatric specialists and subspecialty care, which will depend on sustaining regionalized health services.

Cost Containment Whether budget caps, capitation payments, or price controls, cost containment strategies need to be adjusted to reflect children's different health care needs. When hospitalized, a child requires more resource intensive care per day than an adult or average patient, and children's hospital patients on average are younger, sicker, and poorer than children in general hospitals.

Medicaid's Replacement Medicaid is the nation's largest and most important safety net for children's access to health care. Great care needs to be given to how policies such as Medicaid disproportionate share payments are changed, since they will affect children so significantly.

NACHRI strongly supports the President's leadership in making health reform a national priority, and we strongly support many of the principles his legislation addresses. NACHRI has not endorsed any legislative proposal in detail, but we believe the President's proposal is a good place from which to build a coalition for reform in Congress, both in terms of his fundamental commitments and in terms of his willingness to consider changes in the details.

H.R. 3600—"THE HEALTH SECURITY ACT: THE EFFECT OF HEALTH CARE REFORM ON SMALL BUSINESSES"

TUESDAY, NOVEMBER 16, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to call, at 10:15 a.m., Room 2175, Rayburn House Office Building, Hon. Pat Williams, Chairman, presiding.

Members present: Representatives Williams, Kildee, Becerra, Green, Woolsey, Roukema, Gunderson, Ballenger, Hoekstra, and McKeon.

Staff present: Phyllis Borzi, counsel for employee benefits; John Weintraub, staff director; and Gail Brown-Hubb, staff assistant.

Chairman WILLIAMS. We call to order the committee.

This morning the subcommittee will once again focus on the Health Security Act, and particularly its influence and effect on business, most specifically small business. One of the bedrocks of the President's health reform efforts is security.

For individuals, security means health care that is always there, coverage that doesn't depend on employment or family status. The President's proposal attempts to achieve security for business.

I don't think there is any question but that under the current system or nonsystem, business faces uncertainty and clearly rising costs. Employers providing health insurance have to cope with increased cost shifting and rapidly increasing premiums along with decreasing benefits.

In 1965, business' health care costs represented 12.4 percent of their after-tax profits. Today health care matches profits dollar-for-dollar.

Small business is an important engine in America's economic growth. But the current health care system is stacked against small business. The question is how do we make it better? Health care coverage costs small business owners more and more and offers their employees less and less coverage than employees of big business.

Let me say it again. Employees and the owners of small business get less and less and pay more and more for health coverage than do their counterparts in major American industry. And as we all know, many small businesses can't afford coverage at all. Why? Can't afford it.

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Or if they can afford something, they cannot find an insurance company willing to provide basic coverage at what that employer can afford and that person's employees can afford.

The Health Security Act assures small businesses and their employees the security of access to affordable, we hope—we hope affordable and certainly comprehensive coverage.

We will, after we see if our members have any opening statements, welcome the Administrator of the Small Business Administration here. First, let me ask if my friend and Ranking Member, Mrs. Roukema, has an opening statement.

Mrs. ROUKEMA. Thank you, Mr. Chairman. I do not have a formal opening statement, but I do want to observe that your introductory remarks are extraordinarily interesting. We may be looking at the same issue through different ends of the telescope, but I am not quite sure how that is going to work out in the long debate that we are anticipating here.

Certainly, my measure of the small business community—and we will compare my measurement of the small business community evaluation of the administration health plan with what we hear today. I think it is a particularly relevant panel that we are going to have here.

But presently the small business community sees the mandates and the circumstances of the administration proposals being far more restrictive to them than the present system.

At the same time, we have got to understand that that leaves out of the equation the question of universality and whether or not anyone is going to be covered.

I might say to you as I came in today I wondered how we were going to shift gears here and turn from discussions of NAFTA to fundamentals of health care, because nobody I know has been talking about anything else for the past two weeks except NAFTA. And that is interesting, because I was at a meeting yesterday where I spoke to the Commerce and Industry Association of Northern New Jersey for my annual get-together with them, and we talked about NAFTA and made allusions to the health care situation.

And the first question out of the box was an observation by members of that audience that perhaps health care and the way we resolve that will have a greater negative or positive impact on job growth than anything that has been associated with NAFTA. I don't know if that is completely true, but that is certainly the perception in some elements of the business community. Certainly small- and medium-sized businesses.

Thank you, Mr. Chairman. I am anxious to hear the administration's perspective and will have some relevant questions.

Chairman WILLIAMS. I appreciate my colleague's remarks.

And looking back, Marge, at you through this other end of the telescope, I think if we cannot find a reasonable way to unburden both employees and employers from today's health care costs, and particularly from the costs they will face a few years into the next century, then America will, in fact, be at a disadvantaged position with regard to trade. We now spot our foreign competitors a nickel on every dollar because we pay more for health care than they do.

Now, America can, it seems to me, do two things to right that difficulty. We can either say no employee is going to get health

care, we will have no coverage. American business will have no coverage costs and, therefore, we will compete better with our low health care cost competitors.

Or we can say no, we have to find a way to stem the tide of growing inflation, stop the cost shifting and get all of our people coverage so that we have the security. So it is a Hobson's Choice.

Mrs. ROUKEMA. It is a Hobson's Choice and the question of cost shifting will move to another dimension because somebody is going to pay the cost, whether directly by business community or spread more broadly over the general tax structure. That is a subject for another day, too. Not other day; a continuing dialogue.

Thank you.

Chairman WILLIAMS. Ms. Woolsey.

Ms. WOOLSEY. Thank you, Mr. Chairman.

I am particularly pleased to have Mr. Bowles here today to discuss the President's health care reform proposal and the effect it will have on small business, because you have such a large stake in this health care reform.

As most of you know, I feel strongly that we must reform the current system of health care and move forward with a plan that will give every American access to high quality health care at a price they can afford. But we also must be careful to make sure that no one group assumes an undue burden to finance health care reform. And that is what I hear worries many small business owners.

The San Rafael Chamber of Commerce in my district, the two counties north of San Francisco across the Golden Gate Bridge recently conducted a survey to find out what issues its members felt would have the strongest impact on determining their successes and the success of their business in the future. And these small business owners placed health care reform up at the top of the list.

Many of these businesses are really small; less than five employees. And they believe that any increase in the cost of providing health insurance for their employees could result, at best, in a loss of jobs and in the worst extreme, the complete loss of their businesses. Well, that is a concern to me as their representative.

And as we move forward with health care reform, I believe we must make it possible for small business owners to participate without jeopardizing their businesses. I am hearing from the small business owners in my district through a series of health care forums and we are not quite finished but we have had five out of seven. And I am sure I am hearing the same thing that is being heard across the country; that businesses want to be good employers but they are worried that the new financial mandates could require them to lay off their employees in order to provide health insurance for others and that just doesn't seem right to me.

I am an advocate of the single-payer system of health care. And I know that some businesses feel that the single-payer method would result in far less paper and would spread the financial responsibility of health insurance far more evenly. So I am very interested today to hear what you think about a flat payroll tax deduction as opposed to paying a premium for each employee and any other ideas and suggestions that will help us towards our goal of providing high quality health care for all Americans.

Chairman WILLIAMS. Mr. Ballenger.

Mr. BALLENGER. Yes, Mr. Chairman. I would like to use a number that business people understand and considering that you said health care costs equal after-tax profits, most business people would look at health care costs before taxes, especially since many small businesses, the majority of small businesses that are S corporations are affected by your retroactive tax that we passed, and I think everyone would enjoy it if we could use numbers that we all understand in the business world and not in politics.

Chairman WILLIAMS. Thank you. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman.

I don't have a formal statement, but I would like to welcome Mr. Bowles and Dr. Thorpe here today. I am most interested in hearing their comments with regard to small businesses, but I hope your comments reflect the changing character of small business.

I think within the last decade or two we have seen that many of the small businesses, the mom and pops, are no longer the type of business that we are accustomed to, especially in Los Angeles where such a large percentage of our small businesses are run by men and women who are recent immigrants or minorities. It is a growing field. It is a very important one for many of us in districts that have, when it comes to business, mostly small businessmen and women that generate the jobs.

So I am very interested to hear any comments that you have to share with regard to the effects of any health care plan, not just on small businesses but on men and women who don't necessarily characterize the type of small business we have seen in the last 40 or 50 years, but in the last 15 or 20 years seem to be growing in numbers at least in Los Angeles, Florida, New York, and in areas where the character of small business has changed, but the costs and the burdens are still the same.

Chairman WILLIAMS. Mr. Hoekstra.

Mr. HOEKSTRA. No opening statement.

Chairman WILLIAMS. I want to turn now to Erskine Bowles, the Administrator of the Small Business Administration, a small businessman from Charlotte.

STATEMENT OF HON. ERSKINE B. BOWLES, ADMINISTRATOR, SMALL BUSINESS ADMINISTRATION

Mr. BOWLES. Thank you, Mr. Chairman. I am delighted to be here. I have with me today Dr. Ken Thorpe, the Deputy Assistant Secretary for Health Policy at the Department of Health and Human Services and he will join me in answering questions. What I would like to request is if I could just talk to you from some notes that I made and have my formal comments submitted for the record.

Chairman WILLIAMS. Without objection.

Mr. BOWLES. Congressman Ballenger, who is an old friend of mine, said he wanted to talk in the language of the small business person. I would like to do that, too, because that is my background. I don't hold myself out to be an expert in health care, but I have spent my entire career in the private sector and as a small business person.

I know when I go out and hold the town hall meetings that I have been holding, listening to the concerns of small business people, just like you have, Congresswoman, and I start to talk about GDP and the fact that in this country we pay 14 percent of GDP for health care, whereas none of our competitors pay more than 10 percent, the eyes of small business owners start to glaze over. Then I talk about it in terms that we understand.

I use this example. I said if you have an expense item on your income statement and that expense item accounted for 14 percent of revenues, and you looked at all of your competitors and all of your competitors were paying 8 to 9 percent, you would say, whoa, I have got a problem. And I would really know you had a problem if you looked across the ledger and you saw that you were only covering 86 percent of the marketplace paying 14 percent of revenues and everybody else was covering 100 percent of the marketplace and paying less. That is the crux of the problem.

And when you put it in those terms, the small business people begin to relate to GDP, and then if you tell them that if we don't do anything about covering the health care crisis we have in this country that GDP will go to 20 percent of revenues by the end of this decade they really see the problem we have and they see it firsthand.

As it relates to small businesses themselves, I truly do not believe that you could design a more anti-small business system, or I really would prefer to call it a nonsystem, than the one we have in this country today. As I go around talking to small businesses, I hear the same things over and over again.

Small businesses talk about the annual increase in the cost of health care that they experience of 20 to 50 percent a year. Today, small businesses are paying 35 percent more for the same health insurance that big businesses buy and the rate of increase in the cost of health care for small businesses is 50 percent higher than the rate of increase for big businesses.

And what are the small businesses able to buy for these absolutely skyrocketing increases in the cost of health care? Almost nothing. We end up being able to buy something that is a bare bones plan or something with a huge deductible that only covers catastrophic events. In addition, we are subjected to every single abuse in the health care system, from occupational red lining to exclusions for preexisting conditions.

One of the things that I have done is to serve as the president of the Juvenile Diabetes Foundation. I can't tell you the number of people I talked to who were working in a major company who wanted to leave that major company and start a small business, but couldn't because they were locked in because if they left, they would be naked. They would haven't any health care coverage.

I have talked to any number of small business owners who said, yes, I wanted to supply health care coverage to my employees and you know what, I went out and got a bunch of quotes. Some of them were good, but the ones that were good, the insurance agent said you have to exclude all of those people with preexisting conditions and a year later when those people went on the health care roll, the rates went up so high that you couldn't afford it. We have

the worst of all worlds. Skyrocketing increases in health care and the insurance that we are able to buy is not worth a hoot.

But small businesses have other problems that they want you to think about. A number of you have experienced these problems. One of these I call the hassle factor. A small business person doesn't have a benefits department. We can't sit down and negotiate—even to call it a negotiation is a joke—with the insurance company. They change the name of the rules every day. They have a different set of accounting. There is no way to have a fair negotiation with an insurance company.

And even when we do try to negotiate, we have to take time away from managing our business and dealing with our customers and employees. That is tough for the small business person.

The other problem we have is worker's compensation. The only item on my income statement that rose at a more rapid rate than health insurance was worker's compensation.

A third problem is if you are self-employed, we only get a 25 percent deduction for health care costs; everybody else gets 100 percent. That is wrong. I come from the private sector and I have always believed in private sector solutions, but, you know, I think we have tried everything we can in the private sector as small business people to hold down the cost of health care.

You know, we tried switching programs. We tried managed care. We tried self-insurance. We tried reducing benefits. We tried passing along a bigger portion of the cost to our employees. Nothing helps. The cost of health care continues to rise at 20 to 50 percent a year.

I am here to tell you that I don't believe there is any solution to this health care mess this country is in without universal coverage. I really believe universal coverage is the solution. And I will tell you why. I believe those 37 million people out there who don't have insurance, they get health care, they simply get it at the hospital room instead of a doctor's office and they pay four or five times the cost. And you know who picks that up today? It is arithmetic. We do, the owners of small businesses. That is why our costs go up 20 to 50 percent a year. We pick it up.

Now, I think the President in trying to design a health care plan has tried to focus on those things that the small business owners have said they wanted. First of all, the alliances. I have heard people here talk about the alliances being some kind of big bureaucracy. They are not. They are regulators. They are buying groups, pure and simple. Buying groups.

What the alliances do is shift the power of the marketplace. They change the supply and demand equation from favoring the supplier of health care and the insurance company to favoring us, the consumers and the small business people. They change the supply and demand equation; and where that has been put into effect it has worked. It is not a theory. It has worked in fact.

There is an example in Cleveland that I can give you where it is proven that can you bring down the cost of health care and that you can limit the increase in the cost of it.

The second thing that the President's plan has focused on is simplification. It talks about standardized forms, uniform billings, electronic claims processing. At the average doctor's office I have been

in, a nurse spends 50 percent of her time now filling out forms. The average nurse fills out 19 forms per patient per day. That is crazy. In a hospital authority—I served on the hospital authority at home—25 cents out of every dollar that you spend goes for administrative costs; that doesn't buy you a nickel's worth of health care. Ten cents that we spend on health care goes for fraud and abuse. Ten cents is $90 billion a year. It is crazy.

The President's plan focuses on what I think small businesses need and want. First of all, it provides comprehensive, rock solid real insurance. Insurance that is as good as that offered by any Fortune 500 company. Not some bare bones plan. Not something with a huge deductible, but real insurance. For the first time we get real insurance.

Two, the President made sure it was affordable. That is why those caps and subsidies are in there to drive down the cost of health care so it would be affordable for small businesses. That was something that was very, very important to the President. Yes, it is expensive for the taxpayers. I don't question that.

But it is also important because it holds down the cost for the group that is creating the jobs in this country. The National Association of the Self Employed came out with a study the other day. And, by the way, they do not prefer our plan, they prefer an individual mandate, but they came out with a study that said that the average small business that does not supply health care has an average payroll of about $7,600.

If that is true, that means that small business would be able to provide its employees absolutely rock solid, comprehensive, real insurance at a cost of less than a dollar a day per employee. The total cost on an annual basis, $250 a year. That is something that we can afford. The study said that the average small business that does supply health care coverage to its employees has an average payroll of $15,600.

That small business will be able to provide its employees absolutely rock solid, comprehensive, real insurance at a cost of about $2 a day; $800 a year. You compare that to what you are currently paying and you can see what the benefit is.

The first real insurance: it is affordable and the mechanisms are built in there to hold down the cost of health care so that it doesn't increase at a rate of 20 to 50 percent a year; and the abuses, things like exclusions for preexisting conditions, are outlawed. There is a combination with worker's compensation so that it doesn't grow at the extraordinary rate of the past.

If you are self-employed, you will be able to have a 100 percent deduction. We shifted the power of the marketplace so that we have power and we are able to negotiate with the insurance company to bring down the cost of health care for our employees. Our employees finally get some choice. Nine out of 10 people who have insurance get insurance through where their work. Two-thirds of those employees don't get any choice.

We, the employers, make the decisions, but they will get a choice among three different types of plans. A fee-for-service plan, a PPO and an HMO. And the incentives will be there to hold the cost of health care down.

Now, I believe that the small business people I have talked to said their biggest concern is with the "M" word: mandated. That is what they are concerned about.

I have asked them to look beyond the word "mandate" and look at the facts and do the arithmetic and see what the effects are. And I can assure you that the vast majority will have better coverage at a lower price.

I believe that the vast majority will see better coverage at a lower price. For those small businesses that don't currently offer insurance, there are three reasons I hear as to why they don't.

One is, [A], I can't afford it; [B], if I could afford it, what I can buy just ain't worth a hoot; and [C], boy, if I can afford it today, I won't be able to afford it tomorrow. We have tried to address that. We have tried to give real insurance, comprehensive insurance, rock solid insurance, not just that bare bones plan or catastrophic coverage.

Two, we built in caps and subsidies to hold down the cost so they could afford it and mechanisms so that it can't grow at the rate it has in the past. That is what we tried to do. That is the plan we have tried to put together. And that is why I am so strongly in support of it.

I would be happy to answer any questions that you may have. I did bring Dr. Thorpe who has some graphs that he would like to go over with you.

[The prepared statement of Mr. Bowles follows:]

STATEMENT OF ERSKINE B. BOWLES

Thank you very much, Mr. Chairman, for inviting me here this morning to talk to you about the effects of health care reform on small business. I am accompanied today by Dr. Ken Thorpe, Deputy Assistant Secretary for Health Policy at the Department of Health and Human Services, who will join me in answering any questions you may have on the President's health care plan.

Mr. Chairman, I would like to say up front that I do not believe we could devise a health care system that is more anti-small business than the current health care system that exists in this country.

We spend more for health care than any other nation in the world, and much of this burden is on the back of small businesses.

The President's health care plan, the Health Security Act, represents a comprehensive solution that will benefit small businesses and their workers. The President wanted to be sure that the plan will help small business and that it will provide them with real insurance. As a result, for the first time ever, small business will be able to buy quality, comprehensive insurance at an affordable rate.

Mr. Chairman, I also am concerned by what could happen to our country and to small business if we don't enact comprehensive health care reform and do it now. Let's talk about what the current health care system is doing to our country first, and then what it is doing to small business.

RISING HEALTH COSTS: THE BIG PICTURE

The statistics reflecting the current health care system are frightening. Every month, two million people lose their health care coverage. During the next two years, one out of four

Americans will be without health care coverage for a period of time. There are 37 million Americans without insurance today, and another 22 million who are underinsured.

The rising costs of health care are out of control. The U.S. now spends more per capita on health care than any other country in the world; more than double what Japan spends and 40% more than Canada, which is the country that devotes the second largest percentage of its income to health care.

Twenty-five years ago, health care consumed 5.9% of GDP. In 1992, that number topped 14% to reach a staggering total of $840 billion. By the year 2000 we will see health care spending top $1.6 trillion and cost over 18% of GDP if this trend continues. If we do nothing, health care costs will consume about two-thirds of the increase of GDP in the rest of this decade. Clearly, from a macro economic viewpoint, we have a serious problem in this country with our health care costs.

SKYROCKETING HEALTH CARE COSTS HURT SMALL BUSINESS

Small business is faced with the worst of all worlds with respect to rising health care costs. The small businesses that are still able to afford to provide their employees with health care coverage are experiencing skyrocketing cost increases. Health care costs have increased for small business at a rate of 20% to 50% a year. The administrative load on health insurance premiums is 35 percentage points higher for small businesses than it is for big businesses, and the rate of increase in the cost of health care for small businesses can be as much as 50% higher than the rate of increase for big businesses. Unfortunately, the smaller the company, the more disproportionate are the costs they pay for health insurance.

ABUSES OF CURRENT SYSTEM DISADVANTAGE SMALL BUSINESS

Not only have small businesses experienced skyrocketing increases in the cost of health care, they also have been subjected to blatant abuses that occur within the health care system. These abuses include such practices as occupational redlining, whereby insurers will simply refuse to cover entire industries perceived to be too high a risk. These industries often include such basic businesses as automobile dealerships, florists, grocery stores, barber and beauty shops, construction companies, and trucking firms.

Some insurance companies also engage in price baiting and gouging, by offering discounted rates for the first year of coverage, to be followed by much higher rates in the next year when pre-existing condition exclusions expire. Many insurance companies refuse to renew insurance policies if one of the employees of a small business gets sick and really needs insurance. When this happens, the insurer may either pull the policy or raise the cost to an unaffordable level.

OTHER WAYS THE CURRENT SYSTEM PENALIZES SMALL BUSINESS

Unlike large firms, small business owners generally don't have a benefits department. The small business owner or a valued employee must perform all the functions of such a department. As a result, the small business owner not only loses valuable time away from his business, but he also is at a disadvantage when trying to negotiate the purchase of a benefit for his employees that is extraordinarily complicated to understand and is constantly changing.

A self-employed individual also operates at a disadvantage because of the inequitable tax policies for the self-employed. A

self-employed individual is only allowed to deduct as a business expense up to 25% of the cost of health care coverage. All other businesses are able to deduct the full amount they pay for coverage. This is clearly unfair to the self-employed and almost, by definition, increases their cost of insurance for their families.

Workers' compensation has also become a bigger burden to small business owners. In 1992, medical claims accounted for 41 percent of all workers' compensation benefit payments, up from 33 percent in 1980. Whereas the cost of health care increased by about 102% between 1980 and 1987, the cost of health care in the workers' compensation system rose by 151% during that period.

Clearly, small businesses have a large stake in solving the health care crisis in this country.

SOLUTION: UNIVERSAL COVERAGE

Today, together with individuals, three major groups finance the cost of health care in this country:

1. The government;

2. Self-insured companies -- generally big corporations; and

3. Businesses which insure through traditional insurance companies -- generally small businesses.

These groups finance virtually all of the nation's health care spending. When one of these groups pays less, the others must pay more to cover the cost.

Large, self-insured plans frequently have a great deal of

clout in a given area and can negotiate with providers to reduce the impact of this cost shift on them. Small employers, however, have no ability to reduce this cost shift and must bear its full brunt.

This same cost shifting scenario also occurs when providers deliver uncompensated care, primarily to the uninsured. Make no mistake about it, the uninsured are provided health care in this country. They simply get it at the emergency room at four or five times the cost it would be at the doctor's office. And because there is no insurance coverage, someone has to pay for this treatment. Today much of the cost of the uninsured is shifted to small business. Clearly, no part of the business community is hit harder by the high cost of the uninsured than small business.

A solution that doesn't offer universal coverage for all Americans is simply no solution. Unless the 37 million uninsured Americans are provided insurance, we will continue to have the cost shifting that has gone on in the past. Unfortunately, the sector of the economy that will bear a big portion of this cost shift will be the small businesses.

HOW THE HEALTH SECURITY ACT WORKS FOR SMALL BUSINESS

The Health Security Act provides small business with quality, comprehensive insurance coverage at an affordable rate. The President worked hard to give small business comprehensive and affordable insurance that couldn't be just taken away.

The Health Security Act will control the skyrocketing cost of health insurance by increasing competition in health care, reducing administrative costs, and imposing discipline on the system by giving small businesses and consumers buying clout.

The Act shifts the power of the marketplace to benefit the consumer.

The Act simplifies the health care system and eliminates waste. The plan reduces administrative costs through standardized forms, uniform billing, electronic claims submission, creating a uniform benefits package, and malpractice reform.

The Act also reduces the enormous burden of paperwork and administration that currently falls on small business. The cost of administering coverage in small companies declines because they purchase through health alliances that exercise market power reserved only for large employers in today's system.

The Health Security Act will give small business what it needs by offering:

1. Rock solid, comprehensive insurance coverage -- not a bare bones plan or just catastrophic coverage, but real insurance. The Act will provide discounts to businesses with 75 or fewer workers if their wages average less than $24,000. This is to provide adequate protection with a smooth transition as companies grow in size -- enabling small businesses to continue to thrive and create jobs.

2. Health care costs that are under control to ensure that the cost of health care will increase by approximately the rate of growth of wages, as opposed to current skyrocketing costs.

3. Elimination of abuses of the current health care system. If one worker in a small business or his or her dependent becomes seriously ill, the business will no longer see their rates jacked up beyond belief or lose coverage for the sick

employee or dependent.

4. Full, 100 percent tax deductibility of coverage for the self-employed instead of the current 25% deductibility.

5. Choice to employees to choose their own health plan, something that most employees don't have today.

6. Finally, the plan removes the hassle that small businesses must now undergo in dealing with insurance companies and frees up valuable time for the small business owner to manage and grow his or her business.

In summary, Mr. Chairman, I am confident that when small business owners who provide insurance compare the Health Security Act to their current plan, the vast majority of them will see both a decrease in cost and better coverage. Small business owners who have wanted to offer their employees insurance but couldn't afford it will see a comprehensive plan that they can afford. And those very small businesses that pay low wages are going to be able to offer their employees rock-solid, comprehensive insurance coverage that will cost the small business owner as little as $1.00 to $2.00 a day per employee.

Every small business may not necessarily pay less under the Health Security Act, but the vast majority will. Those small businesses that have been scared off by the constantly escalating cost of health insurance and the relatively poor coverage will see a plan that they can afford to offer.

Mr. Chairman, I am convinced that small business owners, when they examine the facts, will realize the value of the Health Security Act. They will understand that the Act is good for small business.

Thank you.

Chairman WILLIAMS. Dr. Thorpe.

STATEMENT OF KEN THORPE, DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. THORPE. Thank you, Mr. Chairman. It is a pleasure to be here again today in front of you.

I think relating to the Administrator's comments briefly to point out the two charts that we have up there.

One is that on the left-hand side, just to reiterate a major point that Mr. Bowles made, it has to do with the small businesses today that through their vigilance have somehow been able to retain health insurance in today's market. We do have a graph that sort of shows the way the small businesses have to obtain insurance in today's market, and I think the Administrator did an excellent job of summarizing all the major problems.

It is a volatile market where premiums can change almost daily depending on who is sick and who is not. It is a market that is faced with incredibly high administrative costs so the cost of buying an insurance policy that is exactly the same as the insurance policy of a larger corporation is substantially more expensive. It is an insurance market that is characterized by the fact that even if you wanted to go out and buy insurance through all your best intentions, that many industries and individuals, due to preexisting conditions and the fact that you work in a specific industry, you may be redlined and you may not be able to purchase it at almost any price.

I think the fact is that in today's market that the obstacle course that a small business owner has to face in weaving his or her way through the health insurance marketplace is one of the major dilemmas that small businesses face, even for those that really want to offer insurance. Many of those individuals had at one time offered insurance. Today they don't offer insurance because of the hassle factor involved.

It is too expensive. The administrative costs are too high. The day-to-day volatility in the market is such that it diverts a substantial amount of time from the small business operator's attention, the attention that should be fixated on making his or her product.

The second chart to point out more for illustration in terms of where by design we have placed the discounts. By design, the President's plan does two things. One, is that we think that it is equitable and fair and necessary that everybody contributes to health insurance coverage in this country; both employers and individuals.

Second, however, you will see that the design of the contributions are geared based on an individual's and employer's ability to pay; that the discounts, for example, available to employers are heavily weighted towards small, low-wage firms. During the time period that the President's plan—that we have provided numbers on the President's plan between 1996 and the year 2000, the President's plan calls for over $100 billion in discounts going to employers.

You can see from our chart—this is showing just in one year, in 1994 dollars, so in a typical year about $22 billion in discounts would go to provide less expensive, more affordable coverage for

employers to purchase health insurance. You can see that nearly three-quarters of those discounts, or 74 percent of them to be more precise, goes to firms under 25 workers.

We have gone through, I think, at different times the discount schedule, as the Administrator mentioned, for the very lowest wage, smallest firms, those under 25, having a payroll of under $12,000 per year. Their requirements in terms of contributions are limited to 3.5 percent of payroll. That is about a dollar a day for an individual to receive our comprehensive coverage.

So this plan in terms of its design of making insurance affordable is heavily directed in areas where we are most sensitive, which is to the small low-wage business operator. And you can see from the chart that we have brought that that is exactly where these discounts are focused.

Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you.

Administrator Bowles, I visited with some good friends from the Montana Chamber of Commerce last week. The Chamber has task force hearings among their members throughout Montana. Among the things they asked their members is, "do you provide health care, and if you do, what percent of payroll are you paying?"

They shared the results with me, and they were greatly surprised, as I am. By the way, they haven't audited every small business or business in Montana, only those who have attended their events. The least amount that any employer notes as paying is almost 6 percent of payroll costs.

And so, while the debate here should proceed about whether or not small businesses who cannot now afford to pay anything should have to take this mandate, it seems to me, Mr. Administrator, we should follow your advice and at least look at real numbers—and the real numbers are available from the small businesses is that do now provide their employees with health care.

And I wanted that to be on the record as a way to encourage my colleagues to do what I know they are already doing, and that is to get past the word "mandate" and look at the facts of what current care is now costing our constituents.

Mr. Administrator, another thing the Chamber folks and a number of other folks that have visited with me about is this, and I want to frame this as a question. Many businesses today belong to a business coalition or association that self-insures. They simply ask why can't we continue to do it as we do it now? What do you tell them?

Mr. BOWLES. Let me address both of your points, because as many of you know, I held a series of town hall meetings throughout the country. I have been from Connecticut to California, from Des Moines to Atlanta. We have gone out—reached out to folks like NFIB, the National Small Business United, to the Independent Contractors Association and asked them to send their members to these meetings so I could get real input.

We weren't asking people to come just to say they liked our plan. We wanted real input to take it back and report it to the President so that we could have a real understanding of what was on the minds of small businesses. And the input we got from these meet-

ings did lead to some of the changes that we made that are positive for small business in the plan.

But I found out the same thing that you did. That once we were able to get by the "M" word, the mandates, and look at facts of those that were offering insurance, that clearly the vast majority of them found that they would get far better coverage at lower rates. So I have found that also as I have gone and looked and spoken with real small businesses.

Secondly, as it relates to your question about allowing small businesses to self-insure, the big concern that we have or that I have, relates to adverse selection. I believe if you allow those small businesses that have only healthy employees to opt out of the alliance and to opt out of the buying group, you will be left with a buying group that is composed of a pretty weak pool. Therefore you almost guarantee yourself that the price that you pay for your insurance committee pool would be higher than it would be otherwise. So I believe it is very important to have everyone in the pool so that we can bring down the cost of health care for most small businesses.

Chairman WILLIAMS. Thank you. Other business folks have asked myself and other members of the committee why can't we just start small? Why don't we have a bill that permits particularly small employers to voluntarily join health alliances?

Why don't we reform the small group markets, eliminate preexisting conditions? They have other suggestions as well. But the point is, they say Congress should phase in universal coverage over a decade or maybe even more. What do you believe the effects of accepting that suggestion would be?

Mr. BOWLES. I have two answers to that, both based on what I perceive to be reality. First, I believe there is no solution without universal coverage for small businesses. There are really only three basic groups that pay for health care in this country; the government pays for it through medicare and medicaid, big business which normally self-insures, and the small businesses that use conventional insurance.

When we reduce the cost of medicare and medicaid, what happens today is that cost gets shifted and generally the big businesses that have the power to self-insure, they are able to avoid a good portion of that cost and the cost gets shifted onto the back of small businesses. The 37 million people who are uninsured who do get health care coverage at the hospital at four or five times the cost that they would pay in the doctor's office, that is shifted principally on the backs of small business.

That is why we pay 35 percent more and our costs increase at 50 percent a year. I believe that unless you have universal coverage, you will never, ever solve the health care problem we have in this country.

Second, on starting small and working with just voluntary groups, the group I mentioned in Cleveland is one I admire greatly. It is the only truly real success story I know of putting together a large group of small businesses to bring down the cost of health insurance. That group is called COSE, the Council of Smaller Enterprises. It is composed of 13,000 small businesses.

They have been in existence for 17 years. That is the good news and the bad news. They have been able to bring down the cost of health care. The bad news is that it has taken them 17 years to build up a big enough group to bring down the cost of health care.

Lots of groups that have been trying to duplicate what they have done haven't been able to do it. It has taken fanatical leadership to put together this group.

But what they have done, these small businesses have been able to bring down the cost of health care by 35 percent and the rate of increase over the last five years has been 63 percent as opposed to 180 percent. So they have proven that if you can get together the mass, you can bring down the cost of health care. It is simply very difficult. We can't wait 17 years for that to happen in Charlotte or in Hickory or in California.

Chairman WILLIAMS. Thank you. Mrs. Roukema.

Mrs. ROUKEMA. Mr. Chairman, actually you asked my two chief questions. I am not sure that I got the answers but you did ask the question.

I might submit to you, Mr. Bowles, one or two questions in writing that goes into—that asks for a little more clarification as to your cost savings. I am very much from Missouri on all of these cost savings. I believe there can be cost savings. No question about that, but—whether it is doctors and nurses getting better administration and not spending their time filling out forms or whether it is through more efficiency and other ways of delivering and eliminating waste, fraud and abuse as well as some of the defensive medicine that is going on—but I am very skeptical about the magnitude of the cost savings that is projected by yourself or the administration without a severe limitation on access to health care.

So I would like to submit those numbers and they are numbers that I submitted to Dr. Fader and other representatives, Dr. Thorpe, I believe was here on those numbers. Let me submit them to you.

[The information follows:]

QUESTIONS & ANSWERS FOR ERSKINE BOWLES' HEARING BEFORE THE HOUSE EDUCATION AND LABOR COMMITTEE ON NOVEMBER 16, 1993

#1 **The Administration previously advertised their health plan as costing $1,800 for individual coverage and $4,200 for family coverage. In testimony last week, the numbers for 1994 were changed to $1,932 for individuals and $4,360 for families.**

Health care in high cost urban areas today may cost twice this much. When the President went to New York, he said that a family whose coverage costs over $8,000 today would see the cost halved. It doesn't seem possible that a regional health alliance could reduce their baseline premiums in this fashion, virtually overnight.

My question is what the $1,932 and $4,360 figures actually mean. Would they be applicable to any given regional alliance or would they vary alliance by alliance?

Answer

(a) The $1,932 (single) and $4,360 (family) are the preliminary estimates of the national averages for health insurance premiums. These estimates vary by region and alliance, as they would under reform, depending upon variations in input costs for providing care, for differences in health status, and so on. Premium costs may vary within a single alliance as well, such as might be expected for New York City relative to upstate New York. The variation in costs is one reason the President's proposal allows for more than one alliance structure within an individual state.

(b) The premiums represent a national average for the regional alliance participation only.

The elements that went into the methods of estimation are explained in the attached 33 page document titled "Methodological Description of Health Care Reform: Premium and Discount Estimates."

(c) Each alliance will have a per capita premium target set by the National Health Board. Health plans, in turn, have maximum complying bids. In the first year, this maximum complying bid is the regional alliance per capita premium target. If bids exceed this maximum, plans are first given the opportunity to voluntarily reduce their bids, followed by automatic payment reductions sufficient to bring bids within the alliance per capita premium target. The payment reductions will

be calculated using the plan's excess bid amount and adjusting it by an alliance-wide "reduction percentage amount" applied to all plans with bids exceeding the maximum. This reduction percentage amount reflects the alliance weighted average bid for the alliance as well as the proportion of alliance eligible individuals enrolled in each particular plan.

#2 **Who pays for alliance shortfalls? Under section 1571 of the Health Security Act, the Secretary of HHS is given the role of auditing alliance performance in the area of financial management including shortfalls. What is the procedure that HHS will invoke in the event that one of the regional alliances has a funding shortfall? How will the shortfall be paid for and by whom?**

Answer

Under Section 9201 of the Health Security Act, the Secretary of HHS can make loans available through the Treasury in order to cover any temporary period of cash flow shortfall. The Secretary would be empowered to lend to alliances to cover shortfalls due to named specific causes: certain administrative errors, estimating errors (i.e., premium estimation, AFDC and SSI proportion estimation), timing disjunction between receipts and when payments are due. The loans are to repayable with interest over a period not to exceed two years, and can be repaid through adjustments to Federal payments to the alliance, and adjustments to state Maintenance of Effort payments. In addition, the overall amount outstanding at any one time is capped in the legislation itself.

The alliances, then, bear responsibility for collecting the right level of premiums. Procedures for administering needed loans to complement this responsibility will be fully defined in regulation prior to activity.

#3 **According to Secretary Shalala, the National Health Board is "a minor oversight group with some functions." As I understand the National Health Board, it appears to be much more than a minor oversight group. The NHB will oversee all cost containment requirements (p. 256), establish premium tax factors (p. 257), develop a risk adjustment mechanism for premium payments to regional alliances (p. 257), establish minimum capital requirements for state guarantee funds and health plans (p. 258 and p. 282), and promulgate rules for how states pay the debts of a failed plan (p. 103), just to name a few.**

The Health Security Act also gives the NHB the power to hire whatever staff is needed, and delegate any function necessary (p. 259). How many additional staff do you expect

will have to be hired by not only the National Health Board but by HHS and DOL to carry-out the Board's function?

Answer

The National Health Board will be staffed with the fewest number of individuals needed to accomplish its responsibilities. The Board will rely extensively on existing federal personnel at the Departments of Health and Human Services and the Department of Labor, and on private contracts. All activities of all affected agencies will be "on-budget" and open to Congressional oversight and revision.

Please describe the enforcement power of the National Health Board. If the states do not conform to the regulation of the Health Security Act and the National Health Board, who will enforce these regulations? The National Health Board, the Department of Labor, or the Department of Health and Human Services, or whom?

Answer

The enforcement activities of the National Health Board, HHS, DOL, and the Department of Treasury are complimentary; each have responsibilities for various functions under the Act. For example:

- HHS is required to develop financial management standards for the regional alliances, and is responsible for auditing compliance with these requirements. HHS is also responsible for auditing alliance performance to ensure that all eligible individuals are enrolled.

- DOL is responsible for alliance standards and enforcement relating to the employer mandate. DoL is also responsible for developing procedures for appeals of health plan decisions, and for appointing members of the Federal Health Plan Review Board.

- The Department of Treasury is responsible for tax related standards and enforcement.

#4 **Do you consider the minimum health benefits package under the President's plan a federal entitlement or a federal mandate to the states and why?**

If, as I understand, the small business, early retiree, and low-income subsidies provided by the federal government to state health alliances are capped under the President's plan.

Answer

The benefit package is the standard that all plans in the alliance must offer. States, in certifying plans and establishing alliances, must assure that the standard benefit package is offered to everyone and that other rules related to the offering of insurance are enforced (e.g. plans must accept all applicants).

Is it your understanding that these subsidies will not be characterized as federal entitlements?

Answer

The President's plan is a capped entitlement. We have built a fifteen percent cushion into our estimates of what the program will cost over the period 1995-2000, and we have subjected our estimates to rigorous testing against pessimistic economic assumptions. We have also built in a margin of error for elsewhere in our estimates (i.e., the cost of employer discounts; however, only firms smaller than 75 are eligible.) We believe the program will remain in surplus throughout the period.

If, despite our conservative estimates and the inclusion of a fifteen percent margin of error, the projected revenues are insufficient to finance the program, the President is required to make recommendations to the Congress on the best course of action. Just as was the case when the Social Security Trust fund was at risk a decade ago, the President and the Congress will be accountable to the American people to take the necessary and appropriate actions to maintain the stability of our health care system.

Perhaps you can help me understand exactly how the President's plan can promise a fixed package of benefits and say it can never be taken away when the primary source of federal financing is subject to limits and when the total amount of employer mandated contributions is subject to unpredictable fluctuations year-by-year and alliance by alliance? What mechanisms are available to the states and health alliances to meet premium commitments, if the combined state, federal, employer and individual contributions prove insufficient?

Answer

There are a few different and important points to make here. First, the primary source of financing for the HSA is the same source that is primary now: private employers and households paying for their own health insurance. These funds will comprise about 3/4 of all premium spending in the new regional health alliances.

Second, the Administration has built in a 15% cushion to the estimates of discounts under the HSA. This means there is considerable room for fluctuations in the amount of federal money available. Our estimators simulated recessions and strategic behavior on the part of firms, and the cushion more than adequately covered the simulated added expense.

Third, unspent federal discount moneys in any year are accumulated and available should they be needed in future years.

Finally, Alliances can borrow from the Treasury for short term cash shortfalls, to tide them over until premium collection adjustments can be made in subsequent years.

#5 **Under the Clinton plan, it is possible that the weighted average premium for an alliance will increase by more than the 5.2 or other percentage premium cap allowable under the Health Security Act. How will the Administration ensure that the alliance lowers its rate of increase if it is greater than the cap? It is possible that there could be an increase greater than 5.2% in weighted average premium without an increase in costs. If enough individuals choose a higher cost plan in the second year, the weighted average premium will increase by a number greater than the premium cap. Will the National Health Board or HHS force regional alliances to reduce the choice offered to individuals by eliminating some of the high cost plans in order to keep premium cost increases in line with the premium caps? Could that result in the elimination of all fee-for-service plans?**

Answer

You are right that it is theoretically possible for the weighted average premium to exceed the target growth rate if a large enough number of people switch to higher cost plans. It would not be correct to infer, however, that this is a likely outcome. It is contrary to evidence from private companies (Xerox, Alcoa) and state governments (Wisconsin, Minnesota) who have implemented serious plan choice with appropriate incentives for cost-consciousness. It also flies in the face of human nature: why would a vast majority suddenly want to pay more in a market that had just become seriously competitive for the first time ever? This competition is made possible by a whole host of reforms in the HSA, but two are particularly crucial -- standardized benefits and plan report cards. These features make comparison shopping much, much easier.

Finally, in any event, all alliances must ensure at least one fee-for-service plan is available, even if they must actually run it themselves as a single payer entity.

#6 **Who is regional alliance eligible? Section 1571 of the Health Security Act defines the duties of the Secretary of**

HHS. One of the duties that HHS must perform is the auditing of alliance performance by ensuring all regional alliance eligible individuals are enrolled in the health plan. My question is, who exactly is considered eligible? Are resident aliens considered eligible? How will illegal aliens who request health care be treated under the President's plan? Will they be enrolled at the time of their hospital or doctor visit? In fact, how will aliens be identified as illegal - by health providers or by whom?

Answer

Eligibility

An eligible individual is any person who resides in the U.S. and who is a citizen or a national of the U.S., an alien lawfully admitted for permanent residence in the U.S. or a long-term nonimmigrant. Aliens lawfully admitted for permanent residence in the U.S. are defined as an alien who is admitted as a refugee, granted asylum, admitted for residence under the amnesty programs under the INA, one whose deportation is withheld, an alien who has been paroled indefinitely into the U.S. or who has been granted an extended voluntary departure, an alien who is the spouse or unmarried child under the age of 21 of a citizen or the parent of a citizen over age 21 and has applied for permanent residence, and any other classes of permanent resident aliens as the NHB recognizes. Long-term nonimmigrants include: aliens entering under a treaty of commerce or trade and their families and certain temporary workers and trainees.

Medicare-eligible individuals are entitled to benefits through the Medicare program rather than through the HSA unless they are qualified employees or spouses of qualified employees. When individuals become eligible for Medicare, they may choose to enroll in Medicare or to remain in their alliance plan as long as that plan has (or could have) a risk sharing contract with Medicare. Prisoners (who are imprisoned by Federal, state or local authorities following conviction as an adult) are not entitled to coverage under the Act during the term of imprisonment.

Individuals will have the opportunity to register for particular health plans. If they fail to do so, they will be required to pick a health plan at the point of service.

Emergency care for anyone in need will be available through emergency rooms and community and migrant health centers paid for through the existing Medicaid and Public Health Service programs. Primary and preventive care services will continue to be provided through the Public Health Service programs. These services will be available since it is necessary to protect the public's health. For example, it is important that all children are vaccinated and that all persons with active TB receive medical treatment.

When the Department of Health and Human Services finds a regional alliance eligible individual who is not enrolled in the plan, what recourse will HHS have to force individuals into the regional alliance?

Enrollment

The Department of HHS will not be involved in this area. When an individual needs service and has not joined a health plan through a regional alliance, that individual will need to join a health plan at the point of service.

#7 **It was recently stated in the New York Times that "what you pay would no longer depend so much on what you get. Instead, it would be determined even more by where you live and who you are grouped with."**

I suppose the article was referring to the distribution among regional alliances of the various high cost populations -- some who may now be uninsured or insured under government programs.

My question is whether this kind of high cost concentration and cost-shifting could result in businesses in alliances that cover areas like inner cities paying more than businesses in alliances that cover suburban areas? Would you agree or disagree that these artificial boundaries will create new disincentives for business location and favor the employment of residents of low-cost areas?

Answer

Generally, businesses in inner cities face higher costs of doing business than businesses in suburban areas. Under the Health Security Act, however, states designate geographic boundaries for alliances. States will have discretion to form more than one alliance to reflect differences in input costs, as well as referral patterns or use of care providers. What will be important is only that a large enough area be included to assure maximum consumer buying power on the one hand, and some diversity of plans and providers to foster development of multiple competing health networks on the other.

Importantly, states cannot split portions of Metropolitan Statistical Areas (MSAs) into more than one alliance area. Consolidated Metropolitan Statistical Areas are presumed to meet the alliance establishment requirements as well. Community rating of premiums will mean that location alone will not bias premiums faced by employers and employees. Alliances that cover the entire MSA area further helps assure that the same group of high quality health plans are available to eligible individuals and groups, whether they are inner-city poor and more affluent suburban residents.

Overall, then, the Health Security Act will be incentive neutral in businesses choosing a location within statewide areas. Nationally, to the extent that some states are more effective at controlling health costs, businesses may find individual states preferable to others in making location choices.

#8 **The President's plan is quite complex and stretches over 1,342 pages. I presume that small employers who are required to pay into regional alliances will continue to have various recordkeeping and other obligations. Exactly what is the extent of the employer's responsibility? What kinds of records, reports, and so forth would have to be maintained and to whom would they be forwarded?**

Answer

As today, the small employer must maintain records to enable it to keep employees and the regional alliances apprised of the benefits it is providing. Currently, employers providing benefits must keep records and report for tax and ERISA purposes. They also must inform the employees of the services paid for.

The information required to be reported is information that the small employer would have to keep in order to make the required contributions for each employee to the correct regional alliance. Reporting this information to both the employee and the regional alliance allows each to verify that the correct payments have been made.

Under the Act, employers must keep records so that they may make certain annual, monthly and one-time reports.

On an annual basis, employers must provide to persons who were qualifying employees during the previous year the following:

For each regional alliance that the employee obtained a health plan, the total number of months that the employee was employed at least 120 hours per month (i.e., full-time), the amount of wages paid in connection with this employment, the amount of covered wages, the total amount deducted and paid in as the family share, and other information required by the Secretary of Labor.

The employer must provide to regional alliances annually:

The total number of months of full-time employment for each employee and for each class of enrollment and the total amount deducted from wages and paid toward the family share for the employee; the total employer premium payment on behalf of all qualifying employees and, if the small employer's payment is subjected to a discount, the total that would have been paid without the discount; the number of full-time employees for each class of family enrollment; amounts to be paid as part of the employer collection shortfall add-on; and the amount of covered wages for each qualified employee.

On a monthly basis, the employer must provide the regional alliances with information on individuals who changed qualifying employee status during the month, the regional alliance in which the individual resides, and the class of family enrollment.

The National Health Board will specify the initial information that employers must report to regional alliances on behalf of qualifying employees.

Would employers also be responsible to disseminate information on the myriads of health plans offered in, say, a state-wide alliance?

Answer

No, an employer does not disseminate information on the variety of health plans. It is the regional alliance that provides that information, but employers may make this information available to their employees.

#9 **In general, small business is the major source of new jobs in this country. My first question is whether or not your agency (SBA) has determined the number of small businesses and employees who are now engaged in the health insurance and health care industry?**

Answer

According to 1991 data from the U.S. Department of Labor, Bureau of Labor Statistics, there were about 4.5 million jobs in health services industries, which are generally composed by small business. These industries include physician offices, dental offices, nursing, medical dental labs, outpatient care facilities, and personal care facilities.

Secondly, what is the magnitude of effect of the President's plan on those existing businesses?

Answer

The Health Security plan will result in greater employment in the health care sector in the short run and a more efficient health sector in the long run. With the increase in the number of insured Americans and the decrease in the administrative burden of health insurance, there will be a significant expansion of employment of health care providers and a decrease in employment of health administrators and insurance workers. By 1996, as many as 400,000 net new jobs will be created in the health sector. As the cost savings of the plan begin to accrue, employment in the health sector will grow more slowly, although there will be no absolute decline in the number of employees.

Over time, the health sector will become more productive. This benefits all of us. We will be able to have the same or better health care as well as more investment, research and development, or just plain goods and services.

#10 **Under the President's plan, there appears to be great emphasis placed on so-called "subsidies"--that is, subsidies for small employers, for early retirees, for employers whose payroll costs exceed 7.9%, and so forth. My question is, if those receiving these subsidies are not paying their own way, who then will pick up the costs for those being subsidized? Please quantify the amount and source of financing for each subsidy type.**

Answer

The Administration's plan calls for shared responsibility for payment of costs of coverage -- employer, employee, and government. This means that every employer and employee generally must contribute something to the cost of health care, even if that contribution is small.

Overall, current estimates of share of payments under the new system is approximately 58% employer-based, 24% government, and about 18% of payments to come from individuals.

At the same time, to help ease firms into the new system, the plan limits to 7.9 percent the percentage of payroll that would be devoted to health care premiums within the alliance. Premium discounts would be provided by government contributions to alliances. Small, low-wage firms and individuals of modest means would be provided special discounts. And, through the bargaining power of health alliances, premium rates can be lowered from what otherwise would occur.

The 5-year estimates (1995-2000) of Federal expenditures for discounts are currently estimated along the following categories: retirees ($21B), self-employed ($10B), state/local government employees ($2B), private employers ($100B), out-of-pocket discounts for low income ($9B), and individuals/families ($184B).

Funding will come from several sources: a Federal excise tax on tobacco products, slower growth in tax exempt health spending, excluding health insurance from cafeteria plans, tax changes and corporate retiree assessments, and a moderation of growth in entitlements such as Medicare and Medicaid.

#11 Members of your staff recently held a meeting with approximately 40 small business owners to analyze the effect of President Clinton's health care plan on small companies. The business men and women were led through a computer program that prepared various calculations based on their total number of employees, average wages, their anticipated costs of insurance and the value of the government subsidies proposed by the Administration. Because many Members of this Committee have substantial contact with small business each and every day, would you please share with us the methodology used to prepare this small business analysis? Would you also provide the members of this Committee a copy of the program used to prepare the analysis?

Answer

The methodology used to prepare the small business analysis in which we invited small business owners to analyze the cost under the President's plan looked at the fundamental components of the plan that were available at that given date. We have produced a worksheet that can be followed to help estimate costs. A copy is enclosed.

Did the SBA prepare a report regarding the impact of the President's plan on small businesses as a result of this meeting, if so would you please provide us a copy of those findings?

Answer

The SBA has not yet prepared any studies regarding the impact of the President's plan on small businesses. However, because of the considerable stake that our nation's small businesses have in the resolution of the current health care crisis, the SBA's Office of Advocacy has been very involved in the SBA's efforts to educate policy makers and small businesses about health care cost and coverage. Advocacy currently is working on two studies that are relevant to the debate. The first, recently received in draft from the University of Kentucky by the Office of Advocacy, "Measuring the Uninsured by Firm Size and Employment Status," uses 1992 Census Data to contrast the level of insurance offered by firms of differing sizes with percentages of employees in those firms that are covered by health insurance from some source.

The second study, to be conducted by Lewin-VHI, will examine differences in cost and coverage of benefits offered to employees

by firms of differing sizes. The questionnaire for this study is about to be field tested and, if the field test is successful, will be sent to approximately 6000 firms to gather nationally representative data by firm size and demographic characteristics (such as employee age, marital status, gender as well as employer data by industry and geographic region).

These two studies will provide information that will be vital to the ability of the Office of Advocacy to play a very active role in representing the small business point of view in health care reform as it moves through the Congress.

#12 Many employers, particularly the self-insured, have been developing innovative ways of containing health care costs. Many have successfully cut their costs below 7.9 percent of payroll. What provisions in the President's plan will encourage employers under regional alliances to promote good health habits and contain health spending?

Answer

In general, employers will be required to pay a minimum 80 percent and employees 20 percent of an individual's premiums for plan coverage. However, the Administration does allow for employers to contribute more than 80 percent of employees' premiums if the employer desires.

Requiring at least an 80 percent contribution from the employer minimizes the disruption to our current system. Direct contributions to health care coverage by the firm and each individual also can encourage more cost conscious and value-driven decision making by consumers when they choose a health plan or provider for their care. Employers also will have a "stake" in seeing that alliances hold down the cost of health care coverage generally.

Competitive pressures -- both domestic and international -- will reinforce an employer's interest in containing costs within the alliance and in containing costs over time. Improved health and well-being of employees and their families can also translate into higher productivity and increased profits for any employer.

#13 The Small Business Administration, along with the Department of Commerce, spent approximately $82,000 to prepare and publish 200,000 copies of a glossy brochure which outlines the Administration's health care plan. In response to congressional criticism, members of your staff have called the brochure "educational," yet no mention was made of the five other health care plans presently being considered by Congress. Does the SBA plan to produce similar "educational" brochures for the five other health care plans?

Answer

Unfortunately, due to the lack of resources at this time, the SBA does not plan to produce any additional health care brochures. Within the limits of our resources, we are willing to analyze competing plans and disseminate information about them to small business owners.

#14 **Mr. Bowles, it is my understanding that the latest version of the President's plan still excludes any employer with less than 5,000 full-time employees from establishing a corporate alliance. Can you explain why an employer with 4,000, 3,000 or even 500 employees should be prohibited from forming a corporate alliance and self-insuring? What is "magic" about the 5,000 employee threshold? Even allowing for such a high threshold, would the Administration, consider allowing employers who might share a common association (i.e. a local Chamber of Commerce, an industry association, etc.) and, together, have 5,000 employees, to form a corporate alliance and self-insure? If not, why not?**

I also understand the President's plan would require corporate alliances to: (1) pay up to a 1% payroll tax; (2) establish trust funds and reserves; (3) contribute to a newly established federal guarantee fund; and (4) meet cost controls and other reporting requirements. In addition, neither the companies nor their employees would be eligible for the premium cap, early retiree, and other individuals subsidies which are made available only under the regional alliances.

Can you please explain why the Administration would erect these kinds of disincentives to the formation of corporate alliances?

Is this an attempt to force everyone into the government run health alliances?

Answer

The question of firm size is a difficult one and one that Secretary Bentsen and others have expressed a willingness to discuss and examine in collaboration with the Congress. Different proposals now before the Congress define small employers differently -- from 50 or more employees and up.

What will be important is only that a large enough area be included to assure maximum consumer buying power on the one hand, and some diversity of plans and providers to foster development of multiple competing health networks on the other.

The goal is not to force everyone into a government run pool, but to assure comprehensive coverage. Very large enterprises will make the calculation whether maintaining self-insurance through a

corporate alliance or joining a regional alliance is more economical. It is important to note that many firms now self-insure to minimize their exposure to costs for the uninsured. Because under the Health Security Act, there will no longer be uninsured individuals, the cost structure of the health care system as a whole will change.

More specifically, in response to your concerns, several other points are worth noting:

- There are incentives to form a corporate alliance, such as:

  - Experience rating -- regional alliance premiums are community related while corporate alliance premiums are experience rated. Thus, the corporate alliance will pay its covered workers and dependents only, not at the community-wide rates charged in the regional alliance;

  - Self-insurance -- a corporate alliance may continue to offer health benefits through a self-insured plan.

- Concerning the 1% Assessment:

  The 1% assessment does not fund coverage for the unemployed. This assessment is the corporate alliance's contribution to the costs of medical education and the higher costs of academic medical centers. Regional alliances automatically contribute to medical education costs through the premium structure. Medical education and academic medical centers benefit everyone; this assessment means everyone will pay their fair share.

- The Corporate Alliance Health Plan Insolvency Fund:

  This fund pays for health benefits when a corporate alliance health plan cannot provide the guaranteed benefits package and thus is important for universal coverage. Contributions are necessary to maintain solvency, and are imposed only as necessary, e.g., an unusual number of insolvencies occur. The reserve requirements noted in the question are intended to discourage and prevent such an occurrence.

#15 According to recent press reports, the SBA gave 10,000 copies of the health care brochure directly to the Democratic National Committee for it to distribute as a part of its grass-roots lobbying efforts. Can you provide for the Committee how the decision made to provide the 10,000

copies to the DNC, and whether as of today the DNC has reimbursed the American taxpayers for its 10,000 copies?

ANSWER

The SBA did not give 10,000 copies to the DNC. The DNC will pay the costs of their 10,000 copies of the brochure.

#16 **It seems to me that President Clinton's Health Security Act discriminates against larger employers and higher wage employers. The plan includes many disincentives for large companies to continue their self-insured health plans. A one percent payroll tax, establishing and paying into a reserve, and meeting cost controls and other reporting requirements are just a few of the disincentives inherent in the plan.**

The plan also discriminates against higher wage employers. They are not given the subsidies that lower wage employers are offered. This appears to be an incentive that keeps average wages down.

Why does the Health Security Act treat less favorably those employers who offer higher average wages and who may already offer good health benefits?

Answer

(a) Regarding large employers, the Health Security Act does not impose "disincentives" for creation of corporate alliances. Let me raise each of your concerns in turn:

- The 1% assessment is not a special cost paid only by corporate alliances. The assessment is the corporate alliance's contribution to the costs of medical education, and the higher costs of academic medical centers benefit everyone. This assessment means everyone will pay their fair share.

- Trust Funds and Reserve Requirements will be established for all health plans, whether operating in a corporate alliance or regional alliance. This can help assure universal coverage is maintained in the event of any plan;s failure.

  - For corporate alliance plans, the Act establishes a fund to pay for health benefits in the event a self-funded plan fails. All self-funded plans contribute. Once the fund is insolvent, contributions will be assessed only if an unusual number of insolvencies occur. To prevent

insolvencies, self-funded plans are required to maintain reserves equal to the estimated amount that it owes providers at a given time.

- Regional alliance plans may be assessed by the regional alliance to maintain coverage in the event of a plan failure in that alliance. These plans must also meet reserve requirements.

- Reporting Requirements. Each corporate alliance self-insured plan will be required to notify the Secretary if it is not meeting its financial reserve requirements. This provision is designed to protect all other self-funded corporations -- and in effect their employees and families -- from needing to bail out a failed plan. Regional alliances and their health plans are also subject to audit and reporting requirements.

- Cost Controls. Corporate alliances are subject to the Act's limits on premium inflation to the same extent as regional alliances only -- there are no additional "disincentives."

The Health Security Act provides several incentives to encourage the formation of corporate alliances, including:

- Experience rating -- regional alliance premiums are community rated while corporate alliance premiums are experience rated. Thus, the corporate alliance will pay its covered workers and dependents only, not at the community-wide rates charged in the regional alliance;

- Self-insurance -- a corporate alliance may continue to offer health benefits through a self-insured plan.

(b) Regarding your concerns about higher wage employers, these firms are also eligible for discounts. Under the Health Security Act, all firms' outlays for their employees' health coverage will be capped as a percentage of payroll. If costs exceed that cap, all firms are eligible for discounts to pay the excess. The maximum cap is 7.9%; for firms with less than 75 employees and average annual payrolls under $18,000; lower caps apply on a sliding scale.

#17 My concern is over the increased obligation of small employers under the plan. Can you give me an estimate of the number and percentage of small business with less than 100 employees who will have new or increased contribution obligations under the President's health plan?

Answer

According to the 1991 ICF/Lewin Retirement Plan Survey, 93% of firms with between 25-99 employees provide health insurance for their employees. 50.6% of the employers with between 1-24 employees provide health insurance. The percentage of small businesses which will have an increase in contribution obligations under the President's plan will vary depending on whether the firm currently does or does not offer insurance and how much they are paying for that insurance. It is obvious that those firms that currently do not offer health insurance will have a new obligation. The final result, however, will be that the many small firms that currently do provide insurance will be able to offer a comprehensive plan at a more affordable rate.

#18 My question involves the subsidy in regional alliances for early retirees who are age 55 or older but not eligible for Medicare. First, what is the criteria used to define "early retiree" -- does this include the individuals eligible for a pension or could anyone age 55 quit working and receive the government subsidy equal to 80% of the cost of an average health plan? Could this include the self-employed and small business employees who would be laid off?

Answer

The American Health Security Act defines a retiree eligible for a government payment for the 80% employer share of premium as an individual who: 1) is at least 55, but less than 65 years of age; 2) is not employed on a full-time basis; 3) would be eligible (under section 226(a) of the Social Security Act) for hospital insurance benefits under Part A if the individual were 65 years of age based solely on the employment of the individual; and 4) is not a Medicare eligible individual. Employers who currently provide a retiree health benefits package must pay the 20% family share of the premium for their former workers.

What kind of price tag does the Administration place on this early retirement subsidy and what will be the source of financing?

Answer

The early retirement benefits are now estimated to cost approximately $12 billion over the 1995-2000 period. All non-workers, regardless of age, are eligible for subsidies on the eighty percent (or employer) share if their non-wage income is

less than or equal to 250 percent of poverty. The $12 billion noted here reflects the extra cost of subsidizing early-retirees beyond the regular subsidy to non-working families. In addition, government subsidies are offset somewhat by individuals aged 55-64 who work part-time or who have employed spouses. For example, a 58 year old man who is working half time will have fifty percent of the employer share paid by his employer and fifty percent by the government. No government subsidy is necessary when a retiree has a full-time working spouse. These factors combine to limit the costs to the government of this provision.

Will employers who currently have an obligation to pay for early retiree health coverage be excused of this obligation under the President's plan? If so, please provide year by year estimates of current employer obligation and the reduced obligations under the President's plan.

Answer

We do not yet have an industry-by-industry estimate of who will receive the $12 billion in fiscal relief. This would require detailed information, not currently available, on current retiree health provisions in each industry.

#19 **My concern relates to the basis on which employers will have to pay into regional health alliances. My understanding is that employer premium costs will be determined solely by the bidding process and by the structure of the alliance their employees are assigned to -- rather than the health care choices of their employees. There seems to be numerous factors establishing the "weighted average premium" of which employers may pay 80%. Some of these factors in the 1342 page document include: the demographics of the alliance, the "uniform per capita conversion factor", "reinsurance methodology", "premium class factors", "risk-adjustment factors", AFDC, SSI, administrative costs, penalty adjustments for exceeding the premium target, and so forth.**

Could you please explain what role these factors have in establishing a small employer's contribution?

Since these factors are not specific to each employer's workforce, on what basis would you agree or disagree that this employer mandate is anything other than a tax set by each alliance?

In what respect do you think that regional alliances build on the present employer-based system?

Answer

(a) The employer premium costs will be determined by the bidding process between the health plan and the

regional alliance. The bidding process is something that health plans (groups of doctors and insurance companies) must negotiate with their regional alliance. Employees are not "assigned" but will join the regional alliance closest to where they live and choose the health plan they would like to join.

The elements that go into the development of the weighted average premium are more fully explained in the attached 33 page document titled "Methodological Description of Health Care Reform: Premium and Discount Estimates." These factors could change premiums faced by small businesses, but total contributions will still be protected by the general cap on payments as a percentage of payroll. If costs exceed that cap, all firms are eligible for discounts to pay the excess. The maximum cap is 7.9%; for firms with less than 75 employees and average annual payrolls under $18,000; lower caps apply on a sliding scale.

(b) A mandated health insurance premium is not a tax, for several reasons:

1. Health insurance premiums would be paid to the regional health alliances. Taxes are normally paid to the Treasury.

2. The Federal budget deficit is the difference between Federal outlays and Federal receipts. It equals the governments' claim on saving. Unlike other receipts, mandated health insurance premiums would never be available to reduce the Federal budget deficit. For every dollar in "receipts" raised in this way, there would always be exactly one dollar in new outlays. The reason for this is that required premiums are paid not to the government but to regional health alliances. The premiums would not even pass through the Treasury in the current version of the legislation. Even if the IRS were to play a role in collecting the premiums, as long as the premiums have no effect on the deficit, they would not belong in the budget.

3. Most employees already have health insurance benefits paid for by their employers. The President's proposal would not raise "taxes" for firms providing these benefits. If health insurance premiums are a tax, then many employers are already paying it. Indeed, if the plan succeeds in its goal of lowering the rising cost of health insurance, it will produce a large "tax" cut for many of these firms. Counting the required premiums as taxes would give a misleading impression of the true burden of the President's health reform plan for firms that are already providing insurance.

4. The Federal Government imposes many mandates on business that are not recorded in the budget. The requirement that employers contribute to their employees' health insurance is analogous to other requirements, such as rules requiring that employers provide a safe working environment, not hire children, offer employees family leave, or pay the minimum wage. None of these other employer mandates are recorded in the budget as a tax receipt even though many of them impose measurable monetary costs on employers, e.g. the minimum wage.

State governments also impose mandates which are not generally counted toward their budgets. For example, it is common for states to require that automobile drivers purchase liability insurance.

5. Although the premiums are not treated as a tax, the costs of operating the new system of health alliances and the premium revenues that support it will be reported in a supplement to the budget as an information item.

(c) The President's system of regional alliances builds upon the current employer-based system, but is superior because it puts the choice of health care plans where it should be -- with the consumer. The regional alliance system gives individuals information, and empowers them, unencumbered by employer limits on the number or type of plan they select, to make decisions about their health coverage.

Methodological Description of

Health Care Reform Premium and Discount Estimates

Contributions to this paper were made by:

- Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation
- The Office of Management and Budget
- Health Care Financing Administration's Office of the Actuary
- Agency for Health Care Policy and Research
- The Urban Institute's Center for Income and Benefits Policy

Contents

I. Background

Estimates of premium costs, national health spending, and government program costs under health care reform have been necessary in the decisions leading to a health care reform bill. During the basic policy development process, exploration of alternative policies required estimates of the cost impacts of each possible variation. Specific areas included analyses of premium caps, the impacts on businesses of reqiured employer payments, the effects on households of required purchase of coverage, and the budgetary effects of the discount schedules.

The development of estimates of this type is obviously a complex task. Given that no single authoritative data set exists which captures all spending for all services through all sources of funding, numerous data sources were used in this process. Federal surveys, especially the National Medical Expenditure Survey (1987), offer the best characterizations of national spending. The National Health Accounts generated by the Health Care Financing Administration (HCFA) summarize the best available data on total national spending by type of service and source of fund. Producing estimated spending under health reform, however, requires developing a comprehensive baseline summary for literally hundreds of affected sub-populations, and then estimating the future spending patterns associated with the reform.

Estimates of future costs of reform are primarily derived through modeling transfers of current spending among the various channels of payment. Estimating the impacts of changing primary payers is relatively straightforward, given a baseline of national health spending. More difficult is estimating the net impacts of fee upgrades and paying for uncompensated care, since reimbursement levels will be set to achieve some amount of recapture of these increased outlays for current services. Also difficult is estimating the induced spending attributable to new or enriched insurance coverage. Estimates have been based upon experiences of government and private insurers as well as the results of academic studies of the demand for medical care.

Multiple data sources, methodologies, and models were needed to produce estimates of premiums, discounts, and the overall effects of reform options. Major contributors included the Health Care Financing Administration's (HCFA) Office of the Actuary (OAct), the Agency for Health Care Policy and Research (AHCPR), the Treasury Department, and other government agencies. Numerous consultants assisted in the process, with major modeling contributions provided by the Urban Institute. This paper provides an overview of the major models and their ways of estimating premiums, discounts, and overall health spending under health care reform.

II. Description of the Major Models

A. The Urban Institute's Transfer Income Model (TRIM2):

The Urban Institute has developed a microsimulation model called the Transfer Income Model (TRIM2). This model has been used to analyze the financing of national health care reform plans, and has particularly focused on the distributional effects of such proposals. TRIM2 is based upon the March 1992 Current Population Survey (CPS) and combines data from a number of other sources in order to provide a complete basis for assessing acute care health spending by the non-elderly in the U.S. population.[1] The complete model has been aged to 1994, and all results are presented in 1994 dollars. The following description of TRIM2 and its capabilities has been adapted from Zedlewski, Holahan, Blumberg, and Winterbottom (1993).

The TRIM2 model simulates the employer-based group health insurance system, nongroup or individually purchased health insurance, out-of-pocket spending, and the Medicaid program. The model assigns spending under these programs/systems at the individual and family levels and adjusts for regional variation in premium levels. It is then possible to

[1]Historically, TRIM2 has been used to analyze current and alternative tax and transfer programs. See National Research Council (1991) and Lewis and Michel (1990) for a more complete description of the properties of this model and its recent applications.

assess the distributional effects of the financing of the current health care system. Detailed tax calculations allow the analysts to examine health spending on an after-tax basis and to calculate the after-tax value of employment-based health benefits. TRIM2 can also be used to simulate the distribution of health spending and health care financing burdens under alternative assumptions about how insurance would be provided and financed. Each component of the basic model is presented below.[2]

1. **Employment-Based Group Health Insurance.** TRIM2 examines reported insurance coverage for individuals and families on the CPS to determine the number of family members who share coverage under an employment-based policy.[3] The model assigns an employment-based health insurance premium, including the shares paid by the employer and the employee, to each covered worker based on two 1989 private, employer-based surveys (from the Health Insurance Association of America and Foster-Higgins) and federal health insurance plan documents. These private surveys represent firms of different sizes, in all major industries (including state and local government), and in all regions of the country. Federal health insurance plan documents include information about premiums for single and family coverage and how these premiums are distributed between the employer and worker. TRIM2 statistically matches workers to health plans based on variables that the employer insurance plans and workers on the CPS have in common. These include the type of coverage (single or family), location, industry, the size of firm, and whether or not the worker has to pay part of the insurance premium.

2. **Private, Nongroup Health Insurance.** TRIM2 estimates premiums for the families and individuals on the CPS who report insurance coverage through private, nongroup, health insurance policies. It does this by matching these people with plan data collected from Blue Cross and Blue Shield Plan offices across the U.S. Plan documents included premiums for typical health insurance plans covering single individuals, families, and dual (adult and child)

[2]Giannarelli (1992) describes the full TRIM2 model.

[3]Zedlewski (1991) describes this model in more detail.

insurance units in each state. The method does not, however, capture differences due to families' insurance preferences or income levels. For example, if low (or high) income families reporting private, nongroup health insurance are more likely to purchase catastrophic policies, the model will overstate their premiums. Conversely, the model will understate premiums for families who prefer broader coverage than that included in the prototypical plan.

3. **Medicaid.** TRIM2 uses detailed sets of algorithms to replicate the rules of state Medicaid programs.[4] These algorithms identify Medicaid eligibles as all persons who meet the states' categorical, asset, and income criteria in effect July 1991. The model has procedures for selecting Medicaid enrollees from those who are eligible. The second part of the model imputes the insurance value of Medicaid. Separate estimates are made for adults, children, and the disabled; estimates also vary by age, sex, race, urban or rural residence, reason for enrollment, and number of months in the program. The model uses Medicaid state expenditure data to adjust for differences among states in program generosity and the cost of health services.

4. **Out-of-Pocket Spending.** The model uses data from the Consumer Expenditures Survey to predict out-of-pocket spending (other than health insurance premiums) for families on the CPS.[5] Separate equations were estimated for persons with private insurance coverage, Medicaid, and for those uninsured. The equations predict the incidence and levels of spending as a function of families' socioeconomic characteristics including region of residence, income, the age-sex distribution of family members, and the family head's marital status, education, race, and work status.

5. **Income and Payroll Taxes.** The model calculates family disposable income and estimates the amount of income and payroll taxes required to finance health care spending by

[4]See Holahan and Zedlewski (1989) for a full description of this model.

[5]See Wade (1991) for a full description of this model.

the federal government through the Medicaid and Medicare programs. Other federal taxes (such as corporate, estate, and excise taxes) are not included.[6] The portion of Medicaid and Medicare spending that is financed through the federal personal income and payroll tax systems is calculated and can be allocated to families. The model can also calculate income and payroll taxes under the assumption that employer-paid health insurance premiums are taxable to estimate the tax value of this employee benefit.

6. Total Health Care Spending for the Nonelderly. The TRIM2 baseline distribution of direct spending from various sources accounts for most health spending for the nonelderly. The TRIM2 model excludes the institutionalized population. In addition, Medicare benefits for the nonelderly and military health benefits are excluded. Nevertheless, the model accounts for nearly all of the spending under systems that would be most affected by health care reform alternatives currently under debate.

7. Adjustments to TRIM2 Baseline Output. Two significant adjustments were made to the TRIM2 baseline health spending simulations at the request of the office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS). Both employer health insurance premiums and private nongroup health insurance premiums in TRIM2 were downwardly adjusted to reflect health care reform premiums estimated by the Office of the Actuary (OACT). The TRIM2 employer plan data include employer spending for dental care and a few other benefits that not fully covered by the reform package. Without this adjustment for differences in coverage, employer and family spending under reform as calculated in TRIM2 (using HCFA OACT premiums) would not be comparable to employer and family spending under the current system according to TRIM2. Thus, estimated changes in spending under reform compared to current spending would be distorted without reconciling the spending levels.

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[6]However, the TRIM2 model does have the capacity to simulate excise tax payments on alcohol and cigarettes.

B. The Health Care Financing Administration's Special Policy Analysis Model (SPAM):

The Health Care Financing Administration's (HCFA) Special Policy Analysis Model (SPAM) database is also based upon the March 1992 Current Population Survey (CPS). The March 1992 CPS acts as the host file, with each person on it being statistically matched to a person on the 1987 National Medical Expenditure Survey (NMES). Health expenditures and utilization from the NMES person record are then linked to the CPS record, and the entire data set is controlled to be consistent with 1994 National Health Account data.

The parameters used in the linking the NMES file to the CPS were disability status (disabled or not), age and gender (male adult < 19, male adult 19-44, male adult 45-64, male adult 65+, female adult < 19, female adult 19-44, female adult 45-64, female adult 65+, dependent child < 19, and dependent child 19+), family income (family under 100% of poverty, family 100% to 185% of poverty, family at or above 185% of poverty), and insurance class of the person (employer sponsored insurance and Medicare, employer sponsored insurance and Medicaid, other employer sponsored insurance, Medicare and Medicaid and other private insurance, Medicare and Medicaid, Medicare only, Medicaid and other private insurance, Medicaid only, other insurance, and uninsured).

For a CPS person to be considered disabled, one of the following situations had to be true: (a) person was a veteran, collecting veteran's disability, (b) person collected over $10,000 in workers compensation, (c) person had disability income, or (d) person was under 65 and had SSI income. For a NMES person to be considered disabled, one of the following had to be true: (a) person was a disabled veteran, (b) person didn't work due to disability/illness, or (c) person was without a job due to disability/illness.

The determination of adult vs. child was made from "insurance families," which were appended to both the CPS and NMES files. These families were created using standard insurance industry definitions. Within an insurance family there can be one or two adults (single or married couple), and any number of dependent children (or none).

The insurance classifications were hierarchical, and made on the person level using the appropriate variables on both the CPS and NMES. NMES insurance classifications were converted from round data[7] to "ever insured" data (for example, if a person had Medicare in one of the rounds of the NMES survey, they were coded as having Medicare). Poverty classifications were calculated by adding income of all insurance family members together and comparing it to the appropriate poverty standard for the year in question (1991 for the CPS and 1987 for NMES), for the appropriate family size.

Once each CPS person was linked to a NMES record, expenditure data by service (hospital inpatient, hospital outpatient, etc.) and source of payment (out-of-pocket, private insurance, Medicare, Medicaid, etc.) were attached. This file was then aged to 1994 through two steps. First, the 1992 CPS population was weighted to sum to the 1994 Social Security Administration (SSA) non-institutionalized population (about 20 million more than Census estimates). This was done by age (20 age groups), gender and marital status (single, married, divorced, and widowed).

Second, the total national health expenditures by this SSA-weighted CPS population (the SPAM population) were then "benchmarked" by service category, channel of payment, and age category to the aggregate totals in the projected 1994 National Health Accounts. There are 13 service categories: hospital inpatient, hospital outpatient, hospital emergency room, physician inpatient, physician outpatient, physician emergency room, physician office visit, other professionals, prescription drugs, home health care, dental, vision, and other durable medical equipment. There are eight channels of payment: private health insurance, out of pocket, Medicare, Medicaid, other federal, other state and local, workers compensation, and other private. There are three age categories: under 19, 19 to 64, 65 years and over.

An example of how this benchmarking worked is as follows. Suppose the ratio of current

[7]NMES-2, described more fully in the following section, involves 4 surveys of each family over a period of 16 months. Each of the 4 interview sessions is referred to here as a "round."

SPAM out-of-pocket inpatient hospital spending for persons under age 19 to NHA-consistent spending for the same cell is 0.9. Then each SPAM person's inpatient hospital spending total is multiplied by 1.11. The only divergence from this logic was that out-of-pocket spending for the uninsured was controlled separately from out-of-pocket spending for the insured population (which was thought to have risen at a rate closer to the rate of inflation in insurance).

C. The Agency for Health Care Policy and Research's Simulation Model (AHSIM):

AHSIM is based on AHCPR's 1987 National Medical Expenditure Survey (NMES-2), which is the most recent national effort to collect comprehensive, person-level profiles of health care use, spending, and insurance coverage. AHSIM currently is designed only to analyze the nonelderly (under 65), noninstitutionalized civilian population residing in the United States. Although the NMES-2 data were collected in 1987, demographic variables have been aged forward by reweighting individual records. New weights take into account changes in the distribution of the population by age, race, sex, insurance status, and poverty status observed between the November 1987 and March 1992 Current Population Surveys. Additional demographic aging is based on Census projections of the population by age, race, and sex beyond 1992. Real growth in service-specific health expenditures and insurance premiums have been incorporated through adjustments based on the appropriate rates of changes in HCFA's National Health Accounts and its projections.

AHSIM draws primarily on the NMES-2 Household Survey and its two derivative components, the Health Insurance Plan Survey (HIPS) and the Medical Provider Survey. The Household Survey sample is representative of the civilian noninstitutionalized population of the United States in 1987. Each family in the Household Survey was interviewed four times ("rounds") over a period of 16 months to obtain information about the family's health and health care during calendar year 1987. Roughly 35,000 individuals and 14,000 households completed all rounds of data collection. The Medical Provider Survey obtained information directly from the physicians, hospitals, and other providers used by a portion of the household

sample. These data were used to edit and supplement household survey data describing use of and spending on health services. HIPS data were collected from employers, unions, and insurers and include premiums paid by all sources and specific provisions of baseline private insurance coverage. They also provide information about the organizations offering insurance coverage and include in the case of employers, firm and establishment size, industry, and location.

Other data sources were incorporated when needed for specific purposes. For example, survey data from the Health Insurance Association of America were used to project market shares for fee-for-service, HMO, and preferred provider health plans by region. Annual survey data from the American Hospital Association were used to determine the allocation of hospital spending between inpatient and outpatient services and to identify local areas in which at least one HMO is operating. County Business Patterns data were used to impute average payroll for employers, using a statistical match based on industry, location, and firm size. The Internal Revenue Service (IRS) Statistics of Income (SOI) data were used to expand NMES-2 income data and to calibrate the AHSIM tax module. Further details of the basic AHSIM Model are presented below.

1. Employment-Based Group Health Insurance. AHSIM does not model employers, only households and individuals. HIPS and Household Survey data measured the scope of employment-based insurance in 1987, as well as the allocation of premiums among employers, employees, and other sources (primarily unions). AHSIM assumes that any changes in the pattern of availability, benefits, premiums, or other plan provisions between 1987 and 1994 are controlled for in the aging process, using CPS and HCFA aggregate data.

2. Private, Nongroup Health Insurance. AHSIM handles people with private, nongroup insurance in the same way as it does those with employment-based insurance. This means, for example, that a tendency for people with systematically higher medical expenditures to purchase private, nongroup health insurance will be captured in the model.

3. Medicaid. NMES-2 measured Medicaid program participation directly. Since 1987, however, Medicaid eligibility has been expanded to include low-income pregnant women and children who are not otherwise categorically eligible. This Medicaid expansion was incorporated into the ASHIM model by identifying household survey respondents who would have become eligible for Medicaid benefits by 1994 and modifying their baseline insurance status accordingly. Baseline health spending for new Medicaid recipients was also modified to reflect the effect of a changes insurance status, using the same methods that were used to project estimates for the uninsured after reform.

4. Out-of-Pocket Spending. NMES-2 directly measures baseline out-of-pocket (OOP) spending on cost-sharing and noncovered services for all household survey respondents. However, because the AHSIM model cannot use actual NMES-2 expenditure data directly, data on OOP spending reported in the household survey are used to develop a set of estimates that can be incorporated into the model.[8] In particular, a system of equations was estimated to predict the percent of expenses paid out-of-pocket in the baseline as a function of demographic characteristics, insurance coverage, health status, and other relevant explanatory variables. These equations were then used to impute baseline OOP spending as a percent of imputed total spending, by type of service. While baseline expenditures are imputed in the AHSIM Model, they are still internally consistent with the rest of the NMES-2 data because the estimation procedures preserve the pattern of spending observed in the original household survey data.

5. Income and Payroll Taxes. The AHSIM model distinguishes between households and tax filing units. The effect of wage changes induced by employer mandates on federal

[8]Actual NMES-2 expenditure are not used as baseline spending in the AHSIM Model for two reasons. For some people, e.g., those affected by the expansion of Medicaid eligibility, baseline insurance status is different than what is was in 1987 when the NMES data were collected. In addition, it is important that reform expenditures only differ from baseline for reasons related to reform. Because reform expenditures must be predicted for people based on their "new" insurance status, it is helpful to predict baseline spending with the same methodology.

personal income and payroll taxes can be calculated with respect to the 1991 tax treatment of employer paid premiums.

6. Total Health Care Spending for the Nonelderly. The AHSIM baseline includes most health spending by the civilian, resident population of the United States under the age of 65. AHSIM excludes the institutionalized population, Medicare beneficiaries among the nonelderly, and spending by active-duty military personnel.

7. Adjustments to AHSIM Baseline Data. Because the aggregate health insurance premiums reported in the HIPS component of NMES-2 are not consistent with the benefits paid by private health insurance according to either the Household Survey or the National Health Accounts, the NMES-2 HIPS-based premiums are calibrated to these other data sources. Tax estimates and wage income are calibrated to SOI data, as described above. In general, according to extensive analysis by HCFA and AHCPR staff to account for differences in definition and coverage, the NMES-2 expenditure data and the National Health Accounts yield similar estimates.

III. Premium Estimation Under Reform

Two agencies, the Health Care Financing Administration and the Agency for Health Care Policy and Research, estimated the cost of health insurance premiums under reform. Their estimates are in 1994 dollars and reflect the benefits included in the standard benefit package. The premium estimation methodology used by each of these agencies is described below.

A. Health Care Financing Administration:

The first step in HCFA's simulation process was to determine each individual's insurance status. The modelers used CPS indicators for this, and considered a person to be insured if he/she was covered by employer-sponsored insurance, other private insurance, CHAMPUS, Medicare, or Medicaid. Insurance could be either in one's own name or through inclusion in a policy held by an adult in the insurance unit. Also, some dependents are covered by private insurance policies owned by people outside the family (for example, a child of divorced

parents may be covered through insurance carried by the parent who does not live with the child).

HCFA modelers then adjusted health expenditures to reflect the coverage offered through the regional alliance plan. That coverage is restricted to hospital care, physician and other professional services, prescription drugs, and durable medical equipment other than vision and hearing products. Therefore, the analysts excluded all other National Health Accounts expenditure categories. The cost of coverage for mental health, dental, and preventive care in the standard benefit package was estimated separately, from aggregate data, and added in at the end of the process. Once expenses were adjusted for coverage differences, the modelers applied the fee-for-service plan deductibles, coinsurance, and cost-sharing limits to each person covered through the regional alliance.

An insurance-induced demand adjustment was applied to all those enrolled in the regional alliance. The basis for the induced demand was the difference between out-of-pocket spending under current law and that determined by the reform simulation described above. The induction factor varied by type of service. The application of the factors and the specific values used are described in appendix A. Post-induction spending is equal to the expenditures calculated previously plus (minus) the induced spending calculated as described.

Following these steps, HCFA analysts imputed expenses to currently uninsured people. Existing patterns of use for the uninsured person were discarded, because those patterns are influenced by the absence of insurance. An imputation file was created for each service covered under the regional alliance. To create the file, insured people (excluding people who received SSI cash payments) were divided into groups according to gender, four age classes, and three poverty status classes. Expenditures were tabulated for each group to determine: (a) the proportion that had no expenditure and (b) mean expenditures and use for each decile of the user distribution.

Expenses were imputed for an uninsured person using these imputation files. For each

type of service, the person was assigned a random number ranging from 0 to 1. If that random number fell within the nonuser proportion for the service, the person was given no expenditure for the service. Otherwise, the person was given the mean expenditure and use for the decile of users into which the random number placed them. Analysts assumed that facility and physician use was correlated for hospital services, and used the same random number for hospital inpatient and physician inpatient use. They did the same for hospital outpatient and physician outpatient, and for hospital emergency room and physician emergency room use.

Analysts performed a final simulation to determine which people were covered by the alliances. Typically, they excluded people who received AFDC or SSI cash payments. Similarly, most Medicare enrollees were excluded; only those who worked or whose spouse worked were included in the premium calculations. The remaining people were divided between the corporate alliance and the regional alliance according to the worker status of the adults in the insurance family, and were assigned to one of three policies: individuals (and couples with no dependents), one adult plus dependents, and two adults plus dependents. In a final pass through the family's health expenditures, analysts applied the family limits on out-of-pocket spending to determine the plan benefits and copayments.

In order to generate an upper-bound discount estimate, whenever a two-earner couple had one worker in a large firm (5,000 or more workers) and one in a firm that would be covered through a regional alliance, the couple was assumed to choose coverage in the regional alliance. This maximizes the potential cost of the discounts costs given that no government discounts are available through the corporate alliances.

After plan benefits had been determined, premiums were calculated for each of the policy types and alliance types. An offset was applied to expenses to reflect current-law cost-shifting attributable to uncompensated care. Under the current system, private sector premiums are higher than they would be if there were no uncompensated care in the system since providers pass these unpaid costs on to insured, paying patients. Under reform, all

persons will be insured; consequently, baseline premiums should be reduced to reflect the elimination of non-payers from the system. A load factor was applied to the (reduced) benefit cost per policy. The load factor was 15 percent for the regional alliance.

B. Agency for Health Care Policy and Research:

AHCPR's method of generating premium estimates has seven steps. First, following conventions in health economics, AHSIM estimates a two-part model of expenditures for each service. The unit of observation is the person. The first equation in each service's set of two equations estimates the probability of using the service at all as a function of demographic, income, insurance, employment, and health status measures from the 1987 NMES-2. The second equation estimates annual expenditures on the service for all users of the service, as a function of the same explanatory variables. Combining the result of these equations (i.e., multiplying the probability of use times the coefficients in the second equation) yields an equation that predicts expenditures for each type of person. Predicted expenditures are aged to 1994.

Health expenditures for each person are then predicted for each of the ten services included in the AHSIM Model using this system of equations. Predictions for both the probability and the level (given any use) of an expense were made for each person based on these regressions. The procedure assigns the same expected values to people with private insurance and similar personal characteristics, based on a hypothetical "average" insurance policy. Expected values are modified to take into account specific plan provisions using information from the RAND National Health Insurance Experiment about the effects of such provisions. Reform expenditures are imputed to all people in the model using a stochastic process that maintains observed correlations in expenditures across service types while controlling for the demographic characteristics and health status of individual NMES-2 respondents.

Every individual included in the AHSIM Model actually had three types of reform expenditures assigned to them, indicating their (assumed) behavior under fee-for-service

(FFS), managed care (HMO), and preferred provider (PPO) insurance arrangements. Expenses for benefits paid, cost-sharing and noncovered services were calculated separately for each type of plan by applying claims-processing logic to the appropriate estimated expenditure. Premiums for each type of insurance plan were computed on the basis of average benefits paid per insurance policy plus an administrative load set at a percent of benefits paid. In this way, each person was taken into account in computing initial premium levels. Premiums were adjusted for current regional variations in prices.

Individual choice of health plans under reform was modelled by randomly assigning health insurance units to one of the three types of plans (FFS, HMO, PPO) described above. The assumed probabilities of selecting particular plans were based primarily upon market shares observed by HIAA in their annual surveys, trended forward to 1994. These estimates were modified by assuming a 10 percent reduction in FFS under reform as a result of managed competition. Market shares were allowed to vary on the basis of region, urban/rural location, and the availability of discounts for out-of-pocket (OOP) expenses and premiums.

Two passes through the data are made to compute the final set of premiums. The first pass implements decision rules regarding the distribution of premium payments under reform. It also computes the cost of noncovered services and cost-sharing requirements borne by individual households. Based on these calculations, the model determines the extent to which a household's direct costs will be offset by supplemental insurance and OOP discounts. In the second pass through the data, expenditures are increased to reflect additional spending induced by supplemental insurance and OOP discounts. Insurance premiums are then adjusted to reflect these higher expenditures.

C. Choice of Premium Estimates for Budgeting Purposes:

One set of premium estimates had to be chosen for final budgeting purposes. Although AHCPR's premiums were used by that agency in their estimation of discounts to employers and households and those discount estimates were used as a check on estimates done by HCFA and the Urban Institute, the Administration opted to use the HCFA premiums for

purposes of final federal budgeting and distributional effects analyses.

This choice was made for two reasons. First, the premiums estimated by HCFA were higher than those estimated by AHCPR, and it was viewed as desirable to have an official estimate that was more conservative (i.e., that would lead to higher costs associated with the program -- see Table 1 below). Second, the HCFA estimates are benchmarked to the National Health Accounts, the most reliable measure of aggregate spending in the current health care system. Given that the National Health Accounts are considered to be the "gold standard" in measuring total health expenditures, it seemed most appropriate to keep the official premium estimates consistent with that standard.

Table 1

Alliance Premium Estimates

Policy Type:	HCFA	AHCPR
Single	$1933	$1735
Couple	$3865	$3471
One Adult Family	$3894	$3647
Two Adult Family	$4361	$4262

IV. Discount Estimates

The national health care reform plan includes a number of different discounts, targeted at different payers. There are two employer discounts: one directed at all firms in the regional alliance, and one directed at small firms with less than 75 employees. There is a discount for the family share (20 percent of the actuarial value) of premiums and for out-of-pocket

payments for both working and nonworking low income families. There is also a discount for the 80 percent premium share for those families who do not have at least one full time worker (or equivalent), including early retirees. The major models are similar in how they estimate most components.

A. Employer Discounts:

The general firm discount consists of a 7.9 percent of payroll cap on all firm premiums, regardless of firm size, provided the employer is in the regional alliance. If the cost of providing 80 percent of the adjusted premium per worker exceeds 7.9 percent of firm payroll, the share paid by the federal government is equal to the difference between the two amounts, or:

$$[N_S(.8P_S)+N_C(.8P_C)+N_{SP}(.8P_{SP})+N_{DP}(.8P_{DP})]-(.079*\textit{firm payroll})$$

where N is the number of workers of each contract type (S=singles, C=couples without children, SP=single parent families, and DP=dual parent families) and P is the adjusted per worker premium for each contract type.

The small firm discount schedule provides lower payroll caps (less than 7.9 percent) for firms with less than 75 employees and average pay below $24,000 per year. The small firm schedule is shown in Table 2.

Table 2

Small Firm Discounts

Average Firm Payroll	Size of Firm[9] (Number of Employees)		
	Less Than 25	25 to 50	50 to 75
Less $12,000	3.5%	4.4%	5.3%
$12,000-15,000	4.4%	5.3%	6.2%
$15,000-18,000	5.3%	6.2%	7.1%
$18,000-21,000	6.2%	7.1%	7.9%
$21,000-24,000	7.1%	7.9%	7.9%
Greater Than $24,000	7.9%	7.9%	7.9%

[9]Because 75 workers was not a firm size break included in the data sets being used, modelers were asked to use a firm size of 100 for this subsidy calculation. Given that the subsidies will apply only to firms up to size 75, the results overestimate the subsidy costs.

1. **TRIM2: Employer Discounts.** In the TRIM2 model, employer obligations (either 80 percent of the adjusted premium for each worker or a percent of total payroll) are calculated for each worker; there are no firms per se on the CPS, although each worker has employer information associated with them. TRIM2 assigns firm average payroll information from the County Business Patterns (CBP) data to each worker, using a statistical matching procedure that relies on industry (the 3-digit SIC codes), state of residence, and establishment size.

In addition, an average firm premium is imputed to each worker. Take, for example, retail firms with 100-500 workers. Assume that according to the CPS, of the workers who report being employed by that type of firm, 40 percent are singles, 20 percent are married but have no children, 30 percent are married with children, and 10 percent are single parents. The weighted average firm premium that an employer of that type faces is equal to

$$(.4P_S)+(.2P_C)+(.1P_{SP})+(.3P_{DP})$$

where P_S, P_C, P_{SP}, and P_{DP} are as described earlier.

The employer's payment is proxied by the comparison of average pay times the appropriate percentage cap (3.5 percent to 7.9 percent) to 80 percent of the average firm premium. If the 80 percent of the average firm premium is less than capped average pay, the employer would pay 80 percent of the correct adjusted premium for each worker. If, on the other hand, capped average pay is less than 80 percent of the average firm premium, the employer would contribute 7.9 percent (or the appropriate percentage less than 7.9 percent) of total payroll to the alliance.

If the firm cap is the less expensive option, the worker's record is appended with an employer payment equal to the appropriate cap times average pay in the firm. The amount paid by the federal government on behalf of the employer is also added to the record in the amount of:

$$(.80P_i) - (CAP * (Avg.\ Firm\ Pay))$$

where P is the adjusted per worker premium for the worker's health insurance unit type i (single, couple, single parent, dual parent), CAP is equal to the appropriate percentage cap (ranging from 3.5 percent to 7.9 percent) and Avg. Firm Pay is equal to the firm's average payroll as imputed from the CBP data.

If, conversely, 80 percent of the adjusted per worker premium is the less expensive option, the worker's record is appended with an employer payment equal to $.80*P_i$, where i is equal to the appropriate health insurance unit type for that worker, and there is no government employer discount.

2. HCFA: Employer Discounts. In the SPAM model, the basic calculations of employer discounts are similar to those in TRIM2, other than the development of firm-level average payrolls. While TRIM2 imputes payroll data from the County Business Patterns data set, SPAM uses payrolls created by synthesizing firms from employees on the CPS. For each record of an employee on the CPS, one of the firms created using that employee is linked back to serve as the firm description for that employee. The resulting payroll distribution is similar to that implied by the CBP.

3. AHSIM: Employer Discounts. In the AHSIM model, the calculations are also similar to those in TRIM2. AHCPR uses County Business Pattern data for estimating average payroll. The links to NMES-2 make use of the Household Survey detailed responses by firm-size, industry, and other variables, confirmed by the NMES-2 Health Insurance Plan Survey.

B. Discounts for the Self-Employed.

Those individuals who are self-employed are obligated to make a contribution to the alliances based upon the same schedule used to determine small business payments. Those with self-employment income between $0 and $12,000 per year, for example, pay the lesser of 3.5 percent of self-employment income and:

$$(.80 * P_i) - EC$$

where P_i is as before and EC is the credit received by the self-employed person due to employer contributions made on their behalf while doing wage work. So, for example, a self-employed person who is also employed by a firm and who is working a full-time, full- year job for wages/salaries has no further obligation with regard to the 80 percent/employer share. An individual who works full time for wages for 8 months and then quits that job and becomes self-employed is only obligated up to a maximum of 4 months of the 80 percent of the adjusted per worker premium for his/her health insurance unit type.

C. Discounts to Low Income Families.

Low income workers and non-workers (those with family income less than 150 percent of poverty[10]) are eligible for government discounts to assist in the payment of the family share of the premium and to assist with family out-of-pocket payments (co-insurance and deductibles). The family premium share discounts work as follows:

1. Those with family incomes at or above 150 percent of poverty are responsible for paying the full 20 percent share, subject to a maximum of 3.9 percent of family income.

2. Those with family incomes below 150 percent of poverty have their premium obligation calculated as:

$$MARG_1(INC_1 - 1000) + MARG_2(INC_2 - INC_1)$$

where INC_1 is equal to the family income up to the appropriate poverty guideline, INC_2 is equal to family income if it exceeds 100 percent but is less than 150 percent of the appropriate poverty guideline, $MARG_1$ is the contribution rate applied to family income below

[10]The family size specific poverty guidelines used are as follows:
single -- family size is 1
couple -- family size is 2
single parent family -- family size is 3
dual parent family -- family size is 4.

poverty, and $MARG_2$ is the contribution rate applied to family income between 100 and 150 percent of poverty.

The two contribution rates are such that families below poverty do not pay more than 3 percent of income for their family premium share contribution, those with income below \$1000[11] have no premium contribution. Families at 150 percent of poverty pay the full 20 percent share, or 3.9 percent of family income, whichever is less. The government payment is equal to 20 percent of the actuarial premium for the health insurance unit type, less the family contribution calculated above. For purposes of this calculation, family income is equal to adjusted gross income less unemployment compensation plus non-taxable interest income.

For each marginal rate ($MARG_1$ and $MARG_2$), there are two sets of rates to be used. The first set ($MARG_{1single}$, $MARG_{2single}$) is applicable for single health insurance units and uses the poverty guidelines for a family of size one. The second set ($MARG_{1other}$, $MARG_{2other}$) is applicable to all other health insurance units and is based on the poverty guidelines for a family of size four.

Set one is calculated as follows:

$$MARG_{1_{single}} = (0.03 * POVG_1)/(POVG_1 - 1000)$$

$$MARG_{2_{single}} = ((0.2 * PREM_s) - (0.03 * POVG_1))/(0.5 * POVG_1)$$

where $POVG_1$ is based on the poverty guidelines for a family of size one, and $PREM_s$ is the premium for a single individual. In 1994, these rates are estimated to be 3.5 percent and 4.8 percent, respectively.

Set two is calculated as follows:

[11] In 1994 dollars. The income "disregard" is indexed by the CPI in future years.

$$MARG_{1_{other}} = (0.03 * POVG_4)/(POVG_4 - 1000)$$

$$MARG_{2_{other}} = ((0.2 * PREM_{DP}) - (0.03 * POVG_4))/(0.5 * POVG_4)$$

where $POVG_4$ is the poverty guideline for a family of size four, and $PREM_{F2}$ is the premium for a dual parent family. In 1994, these rates are estimated to be 3.2 percent and 5.8 percent, respectively.

These rates result in singles and dual parent families paying their full 20 percent premium share at 150 percent of poverty. At 150 percent of poverty, singles pay 3.6% of their income and dual parents families pay 3.9 percent. When the second set of marginal rates are applied to single parents and couples, these families are paying approximately 3.9 percent of their income at 150 percent of their appropriate poverty guideline (family size set at three for single parents and two for couples); however, that amount is less than 20 percent of their respective premiums. Consequently, couples and single parents with incomes in excess of 150 percent of poverty will be required to pay the lesser of 20 percent of their premium and 3.9 percent of income.

An out-of-pocket spending discount is available for those families below 150 percent of poverty who live in an area that does not provide access to a low cost sharing (HMO) plan. In such cases, the family is only obligated to pay the cost sharing that would be required if the family had actually enrolled in an HMO (i.e., $10 copayment for outpatient services); and discounts will be available for the remainder.

Families without at least one full time worker or equivalent[12] may be required to pay at least some portion of the 80 percent adjusted premium share that is covered for workers

[12]Two examples of families with a "full time worker equivalent" are:
1. each spouse works half time for the full year;
2. one spouse works full time for 8 months and the other works full time for 4 months.

through their employers. Families with non-wage income below 250 percent of poverty are eligible for some subsidization of this obligation. If eligible, a family's payment for this portion of the premium is equal to:

$$MARG_3(NWINC_1 - 1000) + MARG_4(NWINC_2 - NWINC_1)$$

where $NWINC_1$ is equal to the family non-wage income up to the appropriate poverty guideline, $NWINC_2$ is equal to family non-wage income if it exceeds 100 percent but is below 250 percent of the appropriate poverty guideline, $MARG_3$ is the contribution rate applied to family non-wage income below poverty, and $MARG_4$ is the contribution rate applied to family non-wage income between 100 and 250 percent of poverty. $MARG_3$ is set such that families below poverty do not pay more than 5.5 percent of their non-wage income for this portion of the premium, and families with less than $1000 in non-wage income have no required contribution towards this portion of the premium. The federal payment is equal to 80 percent of the appropriate adjusted per worker premium less employer payment credits, less self-employment contributions, and less family contributions as defined above.

Non-wage income is calculated as Adjusted Gross Income (AGI) less wages and salaries less unemployment compensation and less self-employed income.[13] Income in this category includes: rents and royalties, interest (including non-taxable interest income), dividends, alimony, capital gains/losses, the taxable portion of social security, partnerships, and trusts. Aside from items mentioned above, other categories of excluded income are: welfare payments, VA benefits, worker's compensation, child support income, inherited money, and proceeds from life insurance.

There are four sets of contribution rates which can be applied to non-wage income: one each for single, couples, single parent, and dual parent families. They are calculated using the formulas shown below, using the family sizes of 1, 2, 3, and 4 respectively to determine

[13]The actual legislation excludes wages and salaries up to $60,000 per year. Wages and salaries in excess of this amount count towards this calculation. The $60,000 exclusion cap was not modelled, making the subsidy estimates somewhat over-stated.

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poverty guidelines.

For family type 'i':

$$MARG_{3_i} = (0.055 * POVG_i)/(POVG_i - 1000)$$

$$MARG_{4_i} = ((0.8 * P_i) - (0.055 * POVG_i))/(1.5 * POVG_i)$$

where $POVG_i$ is the poverty guideline for the appropriate family size, and P_i is the appropriate adjusted per worker premium. In 1994, these rates are estimated to be as follows: for singles, 6.4 percent and 10.7 percent; for couples, 6.1 percent and 10.9 percent; for single parent units, 6.0 percent and 9.8 percent; for dual parent units, 5.9 percent and 7.5 percent.

These rates were calculated so that families pay their full employer share of the premium at 250 percent of poverty.

D. Retiree Discounts.

Families with retirees[14] are eligible for a special discount. When fully phased in, government discounts cover the full 80 percent/employer share for non-working retirees. Government discounts are offset to some extent by the employers of retirees who work part time and the employers of working spouses. For example, a 58 year old man who is working half time will have half of his employer contributions made by his employer and half of his contributions will be made by the federal government. No government discount is necessary when a retiree has a full time working spouse, as the spouse's employer's contributions will fulfill the coverage responsibility. However, if a retiree is married to a non-worker, the government contribution will cover the couple (or family).

[14]The policy defines retirees as those nonworkers who have fulfilled a requirement of a minimum number of working quarters and who are between the ages of 55 and 64, inclusive. However, the models being used to simulate the cost of the plan do not have data on quarters worked. Consequently, all individuals 55 to 64, who are not working or work part time or part year, are modelled as being eligible for the special retiree subsidy.

E. Choice of Discount Estimates for Budgeting Purposes and Distributional Analyses:

For reasons noted above in the section on premium estimation, the HCFA premiums were selected as the official Administration estimates. This choice necessitated that a model using the HCFA premiums be used as the official Administration discount estimates. For this reason, the discount estimates used for budgeting purposes are from the HCFA simulation model. It should be noted however, that all three discount estimates were within 7 percent of each other. Consequently, all estimates are well within the discount "cushion."[15]

For purposes of distributional analyses, the Administration's official estimates come from the Urban Institute's TRIM2 model, which was benchmarked to the National Health Accounts and which used the HCFA estimated premiums. The Urban Institute is the most experienced of the three groups in doing the type of complex distributional analyses needed for the reform process.

V. National Spending Impacts

The change in spending produced by health reform can be summarized in terms of the impacts on businesses, households, and governments. Present business spending is here limited to employer contributions for employer-sponsored health insurance and for active workers and retirees. Under reform, employers are required to pay 80 percent of the average worker premium in their area (net of discounts) for most workers. Beyond the required outlays, it is expected that there will be supplementation of the required coverage. Those employers currently paying more than the required employer contribution percentage, or buying richer coverage (e.g., lower cost-sharing) are assumed to continue to pay more than the required minimum.

The calculations of changes in business outlays are similar in TRIM2 and SPAM. If an

[15]The HCFA discount estimates were increased by 15 percent in an effort to budget a more conservative level of discounts.

employer currently pays more than 80 percent of premiums, TRIM2 increases employer spending under reform to match the proportion contributed by the employer currently, as long as this does not exceed current spending. If maintenance of the current proportion would exceed current spending, it is assumed that employers increase their spending only to the point of current spending. Worker contributions are reduced accordingly. This first part of supplementation is then increased to add the cost for enhancing the richness of coverage up to the current level of plan richness associated with each currently insured worker. The cost of matching the current richness of benefits is paid by the employer and the worker in proportion to current premium contributions.

In the SPAM model, additional coverage is assumed wherever current payments are better for the family than modeled future payments under the mandated benefit package. Supplementation amounts are accumulated equal to the difference between current and required benefits. Employer contributions are assumed to cover the supplement, although employer payments for the required coverage are held to the mandated minimum.

The AHSIM Model assumes that both employers and households attempt to hold their spending on health insurance constant from baseline to reform. To the extent that baseline spending on employer-sponsored insurance exceeds expenditures required under reform, employers are first assumed to buy down their employees' required contributions. If baseline spending exceeds reform requirements for either households or employers after taking this transfer into account, the AHSIM model then allows both households and employers to buy supplemental insurance. For each health insurance unit in AHSIM, the actuarial value of supplemental insurance purchased under reform cannot exceed baseline levels. The total amount of supplemental insurance is also limited by the level of potential out-of-pocket expenses (cost-sharing plus noncovered services) under reform. Supplemental insurance is also assumed to carry a higher administrative load than basic health plans, 25 percent in most recent simulations. Any employer excess that remains after buying supplemental insurance is assumed to increase other tax-preferred fringe benefits.

Household spending is defined to be the employee contributions for employer-sponsored health insurance, direct premiums for non-group coverage (under the current system) or direct purchase of alliance coverage (under reform), and cost-sharing payments. In the baseline, the employee contributions are defined to include employee payments irrespective of tax status; pre-tax employee contributions are counted as employee payments despite IRS treatment of such sums as employer contributions. To the extent supplementation implies higher business payments, household spending is reduced by like amounts. Total changes in cost-sharing are calculated as the net of reduced payments due to new and enriched coverage, against increased cost-sharing attributable to required purchase of insurance leading to increased utilization and some personal payments (rather than reliance on uncompensated care mechanisms).

Government spending changes reflect transfers between the Federal government and other levels of government, as well as increased Federal responsibilities (particularly in arranging discounts for low-wage firms). Baseline Federal spending is primarily Medicaid and Medicare. Under reform, Medicaid non-cash populations move into alliance plans, with some direct business payments. Similarly, more Medicare recipients fall under working aged rules, with direct employer contributions reducing Medicare responsibilities.

State and local baseline spending is primarily Medicaid, although significant sums are currently spent on other programs, most notably direct payments to hospitals. Under reform, Medicaid savings will be redirected under maintenance of effort requirements for use in paying for discounts for low-income populations in the alliances.

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APPENDIX A

Example of the Application of an Induction Factor To a Change in Insurance Status

	Before Change	After Change
Current law spending	$200	$200
Multiplied by copayment rate	x 50%	x 20%
Out-of-pocket spending	$100	$40
Initial change in out-of-pocket		$60
Multiplied by induction factor		x 0.7
Equals change in total spending		$42
Current law spending		$200
Plus induced demand		42
Equals new total spending		242
Less new out-of-pocket (20%)		- 48
Equals new benefits		194

Induction Factors Used in SPAM Simulations

Hospital inpatient (facility and physician)	0.3
Prescription drugs	1.0
Emergency room services and DME	0.0
All other services	0.7

SOURCE: Office of the Actuary
Health Care Financing Administration

HEALTH SECURITY ACT EMPLOYER PREMIUM WORKSHEET

By carefully following this step-by-step worksheet, you will be able to calculate your estimated health insurance costs under the Health Security Act, as proposed*.

WHAT THE EMPLOYER WILL PAY UNDER THE HEALTH SECURITY ACT:
Under the Act, you will pay the lesser of:

Option (1) 80 percent of the adjusted premium for each full-time worker plus a pro-rated share for part-time/seasonal workers, or
Option (2) A fixed percentage of your firm's total payroll.

CALCULATING MONTHLY EMPLOYER PREMIUM PAYMENTS
Option (1)

		INDIVIDUAL	COUPLE	FAMILY	TOTAL
1.	Number of full-time employees.	_____	_____	_____	_____
2.	Total monthly hours worked by part-time and/or seasonal employees.	_____	_____	_____	_____
3.	Divide line 2 by 120 hours. This is the full-time employee equivalent for part-time employees.	_____	_____	_____	_____
4.	Add line 1 and 3. This is the company's total full-time equivalent number of employees.	_____	_____	_____	_____
5.	Multiply line 4 by premium cost on line 5.	$1,549	$2,125	$2,479	
6.	Enter amount here.	_____	_____	_____	_____

6. Using the average wage calculated on Line 5 above, look up the small business discount on the last page and multiply the appropriate discount factor by the company's total payroll. Enter amount here. _____

7. Divide line 6 by the number 12. This is the total monthly premium payment cost for all of the full-time equivalent employees. _____

* This worksheet was accurate as of January 14, 1994. To the extent that changes in the Health Security Act occur subsequently, further revisions to the worksheet may become necessary to assure continued accuracy.

Your actual monthly health insurance costs will be the lesser of the amount on line 8 Option (1) or the amount on line 7, Option (2).

Note: **Under Option (1)** above, you are not required to make contributions on behalf of employees who are under the age of 24 and are full-time students. Individuals under the age of 18 (regardless of student status) are also excluded and will be covered through the policies held by their parents. You are responsible for employees over the age of 18 who are not full-time students. Under Option (2), however, the payroll of the above mentioned individuals is included for purposes of the percentage calculation.

Note: **SUBCHAPTER S CORPORATIONS:** If you receive your income from a service related business, materially participate in the activities of the S corporation, and you own 2 percent or more of the stock, your wages would be treated as "net earnings from self-employment" and must be included in the total payroll.

* **Please note:** The discounts are based on an annual retrospective look at the company's payroll and average wage per employee. These premium amounts will have to be estimated monthly and reconciled in February of the following year.

Mrs. ROUKEMA. Dr. Thorpe, you referred to discounts. Are you referring to the subsidies? Are the discounts synonymous with the subsidies in the President's plan?

Mr. THORPE. Yes, by discounts, what it is, is it lays a price schedule which is a discount off the price of full health insurance.

Mrs. ROUKEMA. Who pays the difference?

Mr. THORPE. The difference would be paid out of the pool of money that we have laid out in the President's proposal underneath to cap entitlements.

Mrs. ROUKEMA. I see. All right. Now, Mr. Bowles, address again, let me ask the question a little differently. I heard your statement on universality, but it seems to me that if we begin incrementally with the most egregious part of the gap, which is insurance reform in terms of portability, as well as eliminating preexisting condition or cancellation on that basis, can we not solve a great portion of our problem in that regard and then perhaps take up what some others, such as Senator Chafee, has proposed to fill in the gap with redefining the poverty level or at least coverage over 250 percent of poverty level, and fill in that gap as an immediate first step, rather than going to what seems to many of us to be an intrusive, convoluted bureaucracy that may have some unintended consequences in the way that the costs are shifted within those alliances, particularly in an area like mine which is so close to the urban problems of the New York metropolitan area?

Mr. BOWLES. First of all, I am sure that you can't tell from my accent, but I lived in New York for a long time. No one ever accused me of sounding like a New Yorker.

First of all, there are many things in the Chafee bill that I like. Secondly, and the principal among it is universal coverage. I think the Chafee bill does address the universal coverage need, and therefore that is the principal thing within that plan that I favor and favor strongly.

Secondly, I strongly believe that we do need to address the abuses that are in the health care system and particularly those that affect small businesses, as you discussed, the portability, the exclusions for preexisting conditions. Those are absolutely, totally, in my opinion, unacceptable and unfair to small businesses.

However, I don't believe, going back to your central point, that if we do not have universal coverage, that we can really solve the problem of having affordable health care available for small businesses. I think if we don't have universal coverage, we will continue to have the cost shifting that has occurred in the past into the future and that cost will principally be shifted onto the backs of small businesses.

Mrs. ROUKEMA. That is all, Mr. Chairman.

Chairman WILLIAMS. Ms. Woolsey.

Ms. WOOLSEY. Thank you. I knew I was going to find you very interesting. I think you are wonderful.

Before I got here, 25 years I was a human resources professional, and as an executive for a growing electronics company, and then later human resources consultant and I have spent many, many years—25 to be exact—shopping insurance benefits and implementing benefits and finding that small businesses could not have H.R.

departments and benefit departments, therefore, I was the person that they hired to do that.

And as the cost—as they went out of sight and the benefits became less and less, I find my clients becoming more and more frustrated, but one of the things that frustrated them the most was the complication and the administration, so I am going to ask you the question again about simplicity and if it wouldn't be easier to have a flat percentage of payroll tax for health insurance versus insurance premiums for each individual employee; a payroll tax that would be shared by the employee and the employer. Have you thought about that? Or does it matter in that that is not what the administration wants?

Mr. BOWLES. Oh, no, no. I think the great thing about having a chance to work in this administration is that you do have an opportunity to look at all the options. And we have explored each one of those options and tried to think about what kind of effect it would have on each and every different kind of group and each and every different person and tried to look at it. And it really has been an extraordinary process to go through. So yes, we have had a chance to think about it.

First, if I could just address the complexity issue itself and then go to the single payer solution. From my viewpoint, you couldn't have a health care system that was more complex than the one we have now.

I mean, you talked about it earlier having been in the human resource area. And looked at the raft of forms that are involved today and looked at the fact that you have to pay on a procedure-by-procedure basis. And when you look at insurance policies that are currently offered, you have to really look at the fine print to see what is covered and what is not covered, and unfortunately you often find out too late that a benefit that you thought you had provided your employees really isn't there because it has been excluded for one reason or other.

As you look to the future under our plan, I think what we have really tried to do is to make it much simpler, we have really tried to take some of the complexity out of the system by going to single forms, single bills and uniform bills and standardized forms. And we have also tried to take the hassle out of it for the employer so that they don't have to take time away from their valued business; and we tried to put that in the hands of the alliances.

What we have really tried to do is to build on the present system of our private sector health care insurance of employer-based coverage, of choice of doctors and plans, and the quality health care system that we provide here in this country today. Really, as I look at it what we are doing is we are setting some standards. We are providing security.

We are guaranteeing choice and quality, and then we are going to get out of the way. As I look at the single-payer plan, there are a number of things I like about it. I like the universal coverage portion of it. I think that is critical. I stated that earlier, the comprehensive benefits.

You know, clearly that is something that I believe to be important, because I think small businesses deserve to have comprehensive benefits. The cost controls that are built in there I like. I like

the administrative simplification of it and the reduced paperwork, so I do like those two things that you referred to.

What I didn't like as I looked at it, the things that I didn't think made as much sense—is to get rid of our current health care system and make such a radical change when it is possible to build on the current system of private sector health insurance.

Nine out of 10 people in the country today that have health care are provided that health care at work; and I felt it was possible to build on our present system. Also, as I looked at bureaucracy that would have to be built up to have a single-payer plan, that was not something that I felt as comfortable with. I felt we could have less bureaucracy, going with far less bureaucracy going with the system that was offered by the President.

The last thing that concerned me about the single payer plan was the kind of one-size-fits-all. In my opinion, what works in New York doesn't necessarily work in New Mexico. What works in North Carolina doesn't necessarily work in North Dakota.

And, my hope was that we could build a plan that would truly allow flexibility among the States to do what was in the best interest of each individual State to push the decisionmaking power down to where the people really are.

Ms. WOOLSEY. Well, I guess I want to respond to that, that I am having a hard time building on something that I don't think is working at all.

Can I ask you a question? You mentioned the one dollar and the two dollar; is that for the employer's contribution or is that the employer and the employee?

Mr. BOWLES. The employee.

Ms. WOOLSEY. So it would be $1.20 or $2.20?

Mr. BOWLES. I think in the second example the cost was $2.25, and not $2.

Chairman WILLIAMS. Mr. Gunderson.

Mr. GUNDERSON. Thank you, Mr. Chairman. You are a good advocate on behalf of administration's proposal and I commend you for that. A couple of questions. The small business subsidy, there seems to be a lot of concern as to whether this is a temporary or permanent subsidy. Can you give us some indication of whether this is meant to be a permanent subsidy?

Mr. BOWLES. I have seen nothing anywhere that would lead me to believe anything other than it was a permanent subsidy; that it was going to be forever.

Mr. GUNDERSON. Has it been costed out over the long term? Can you give us exactly what the cost of the subsidy would be for the next six years?

Mr. BOWLES. For the next six years, yes, it is about $100 billion. For the next six years, $100 billion total for the employer portion of the subsidy.

Mr. GUNDERSON. Explain that to me. If you have $22 billion the first year, times six you get over $100. And if it is $22 billion the first year, it is clearly going to be a lot more as you get this thing phased in.

Mr. THORPE. If I could, the $100 billion figure referred to the period 1996 to the year 2000. We would have the plan phased in so that all Americans are covered by 12/31/97. So the difference is

simply due to the fact that in 1996 and parts of 1997, we are phasing in coverage so we don't have a full year cost.

Mr. GUNDERSON. Full year implementation is fiscal year 1997?

Mr. THORPE. Right; 12/31/97.

Mr. GUNDERSON. So for the first full year of implementation, the projected cost is how much?

Mr. THORPE. For the employer? The total for employers and employees is about $13 billion in fiscal year 1996. That is the total cost of the discounts. And the employer piece of this is in the $4 billion to $5 billion range.

Mr. GUNDERSON. I don't want to come off dumb in the Education Committee room, but if full implementation in fiscal year 1996 is $13 billion, how do we have $22.4 billion?

Mr. THORPE. The 1996 number that I just read is assuming that only 15 percent of the population would be phased in during 1996. The number that I am showing you up here is showing in 1994 dollars what the employer discounts would cost, assuming that everybody was in the system.

Mr. GUNDERSON. You are assuming only 15 percent are eligible?

Mr. THORPE. No. We think that basically what we have done is spend a substantial amount of time surveying States, and since it is up to the State to make a decision between 1996 and the end of 1997 when to come in. It is based on our surveys of States and their representatives about when they might come into the system.

Mr. BOWLES. As an example, in 1998, which is the first full year of implementation, which is what I think you are shooting at the gross number, is about $20 billion, but that is reduced by the offsets from medicaid and medicare. That is a gross number, not a net number.

Mr. GUNDERSON. So $20 billion is the gross subsidy per year?

Mr. BOWLES. Right.

Mr. GUNDERSON. And you are assuming that there is going to be a small number of people, primarily on medicaid, who would be now covered under the employer payment. Do you have that calculation?

Mr. BOWLES. I do, but I don't have a direct offset against that one particular portion. I have an offset against a total combined portion of all of the discounts that we have. The discounts add up to $349 billion over a five-year period. The offsets are about $188 million. Bringing it down to the number that you have seen many times in the paper. I have it on a gross basis, not the individual amount of the discount that is offset against the employer portion of the discount.

Mr. GUNDERSON. What number of firms do you project will qualify for this subsidy? Do have you those numbers yet or no?

Mr. BOWLES. I do not.

Mr. THORPE. We do. I don't have them with me today, Mr. Gunderson. We will be happy to provide them for the record.

Mr. GUNDERSON. I think that would be helpful. I wanted to get at something that you articulated which philosophically I agree with. I also reject the one-size-fits-all. It confounds me that in terms of self-insured that if a small business says we are willing to meet the minimum benefits standards established by the National Health Board, and we are willing to pay a risk assessment,

risk assessment for sharing the risk that, we still wouldn't be allowed to run our self-insurance program. Why would we deny them that opportunity if they share in the risk-sharing and they meet the minimum benefit standards?

Mr. BOWLES. It really does go back to the subject I talked about earlier. The people who would opt out of the pools, would be the ones who have healthy employees.

Mr. GUNDERSON. That doesn't matter, sir. If you have a risk-sharing assessment formula based on the disproportionate representation of their workforce, they pay a higher risk-sharing contribution, that doesn't matter. I mean, I would buy that if we weren't going to have a risk-sharing assessment, but these companies in my district and elsewhere say we will pay the risk-sharing assessment, whatever that formula says we got to pay. Let us run our over program so that we know what it is. Why would we deny them that opportunity if they are willing to do that?

Mr. THORPE. I think the other 13 we talked about—there really are two reasons. One is the selection issue and you raised a potential way of thinking about addressing that by applying the risk adjustors inside and outside the alliances. I would have to think about that.

But the second thing that is the problem, is that I think to the extent that you continue to fragment the purchasing pool. This is a purchasing pool that is trying to change the relative bargaining strains between buyers and sellers. When I have looked at data on the size of company that is able to extract not only a discount but a sustained discount over time, one of the main reasons why you ended up with a corporate alliance of about 5,000 is that it wasn't until you got up to firms of about that size that had that type of negotiating power in the market. The firms in the 100, 200, even 250 size frame didn't have the clout, even though they are self-insured, to negotiate sustained discounts in the market and if you are fragmenting the purchasing pool, you are taking away one of the main reasons to have it, to consolidate purchasing power.

Mr. GUNDERSON. The only reason I am pushing this is that everyone I talk to in the administration about it, including Mrs. Clinton, agrees with me but I never see any result. Purchasing clout in Washington, DC is different from purchasing clout in Barron, Wisconsin. I have a firm with 2,500 employees that has negotiated out a contract to guarantee that the small town rural providers would be the primary provider. They have not only dealt with the cost savings and money issues, but with the access issue which is equally important here.

And yet your plan, as written today, tells this firm that no matter how good they are, and how much they have saved and no matter whether they are willing to do a cost sharing assessment, they still can't participate under their own self-insured program in the future. If the overriding goal of the administration's plan is universal coverage, then you ought to be willing to accept anybody who accomplishes that.

And here is a company that does that and they will share in the risk. And you still have told them no. And I mean, if I sound frustrated it is only because this is the eighth conversation I have had with the administration and no one has yet given me a good argu-

ment about why what I am saying is not making sense, and no one has given me any indication that they are going to incorporate it. I am frustrated.

Chairman WILLIAMS. Mr. Administrator, you may want to respond to that, but the gentleman's time has expired.

Mr. BOWLES. I think that is one of those things that I want to go back and think about and if I decide that it makes common sense, I promise you I will carry that message. I had not looked at it in the matter that you described it.

I was trying to prevent those small businesses that really didn't have the healthy group of employees from getting lumped in the pool where they wouldn't have the purchasing power that Ken was referring to, or two, would be left in the pool that would be such a weak pool that it would not be able to negotiate effectively the kind of rates I think are important to bring the cost of health care down for all small businesses.

I will look at your point, and I will respond to you on it. I think it is a good one.

Chairman WILLIAMS. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman. Just a couple of questions with regard to disseminating information on the plan. What is SBA doing or the administration, in particular, doing with regard to informing the small businessmen and women out there of what is in this particular plan?

I know that have you mentioned some of the town hall meetings that you have held. I suspect that everyone up here has held town hall meetings.

But more specifically, is there any formalized plan to approach the small businessmen and women, especially that business person who rarely has a chance to stay abreast of what is going on in Washington, DC or the State capital because they are so occupied in the business; the plumber who rarely stays in a particular office by the phone. How do you make sure that those folks understand how they will be impacted by whatever plan ultimately comes out?

Mr. BOWLES. It is very difficult to do it on a cost-effective basis. We had looked at having a 1–800 number where people could call in and ask questions and find out what their health care cost would be today versus what it would cost under reform. And the ideal is for them to not just see under the administration's plan, but also under alternate plan what their health care costs would be.

We simply could not afford it. It costs too much money. Once we looked at what kind of equipment we would have to buy and the number of people that we would have to assign to it, it was just something that we could not afford to do. We are making every effort to go out and speak to as many small business groups as we possibly can. I know I can't literally speak to any more than I am now.

I am doing almost two to three a day trying to be sure that small businesses have a chance to understand the good and weak points of all the plans that are out there. So that they can have a chance to make an informed decision. It is a difficult problem to address.

We are asking each one of the people in our SBA district offices to make as many presentations as they can to discuss the health

care plan. We are trying to disseminate as much information about the plan as we possibly can.

Mr. BECERRA. I would urge to you send down the instruction to the district offices to work with the Members of Congress as they can. There is no way that the government can afford to go out there and reach out to everyone, but especially small businessmen and women who will see a sea change in the way they do their business, it is important that we get the word out to them.

One other question. The uprising, the riots that took place in Los Angeles recently required a yeoman's effort on the part of SBA and there are still a lot of folks in Los Angeles who are suffering from the effects of what occurred a year or two ago. There is a community—I represent a large Korean American community in Los Angeles that because of communication problems and linguistic cultural problems, communicating with a number of the different agencies has had a difficult time receiving all the assistance that they believe it was due and I also believe it was due.

A lot of it was that SBA funds ran out; and a lot of this took place before your watch. But I am wondering if there is anything that will be done by SBA, given its limited resources, to make sure that on something like health care, although it is not a catastrophe, that we will not run into the same situation that we ran into with the LA riots where we found there was not enough assistance and personnel, and most importantly the inability to connect with the person who needed the assistance immediately.

Mr. BOWLES. I can treat that easily. If you look at the organization structure of the SBA historically, it was not organized as an efficient, effective operation. Over the last 15 years or so, the number of people who work at the SBA has not been changed. We have about 4,000 employees, but there has been a significant shift in where those employees are.

Prior administrations took people out of the field and transferred them to our 10 regional offices or to Washington. So if you look at us today, in my opinion, we have way too many people in Washington, and way too many people in our regions. And we have too many regions and not enough people down where our customers are. And they are the owners of small businesses.

We are going to have a reorganization plan now. I have submitted that plan already to the President. That plan calls for a change in philosophy.

I subscribe to the philosophy that you ought to put your assets where your customers are. Our customers are the owners of small businesses. We hope to transfer as many as 200, perhaps more people, from Washington to the field. And we hope to transfer an additional number of people from our regions down to the districts so that we can deliver the kind of service that your constituents, my customers, demand.

We are focused on that. We want to be in a position where we can be proactive rather than just simply reactive. We can do this and save the taxpayers a considerable amount of money and operate more efficiently and effectively. We will take some of those dollars and reinvest them in electronic communications.

Mr. BECERRA. I think that is prudent. I will leave with you a letter that I have for you to discuss that issue more in the future. Thank you.

Chairman WILLIAMS. Mr. McKeon.

Mr. MCKEON. Thank you. Being a small businessman before I came here, I appreciate hearing what I just heard.

We had problems getting much help in the past from the SBA. I think this would be a good move. I have talked to some large businesses, and they really like the President's plan because it will cut their costs. And when Mr. Williams talks about the people that he talked to in Montana who are small businesses that are paying $6, they are probably excited about it because it will cut their costs.

I guess I am wondering then who is going to pay for the 37 million, assuming that is the number, who are uninsured. They are probably excited because somebody is going to start covering them. Who is going to pay all of these costs for everybody that is having their costs cut?

Mr. BOWLES. Is that your question?

Mr. MCKEON. That is one of them.

Mr. BOWLES. Let me first address realistically, because we believe a lot of the costs will be paid through savings by operating a more efficient, more effective system. And again, you know, these savings are not something that people have dreamed up just in theory.

We should be able to bring down the cost of health care truly by shifting the power of the marketplace, by changing the supply and demand equation, things that you understand—I think you owned clothing stores, I remember in prior days. But by having some market force, we can reduce the cost of health care.

We can give some power on our side as opposed to having all the power on the supply side. That in its own right will bring down the cost of health care. Doing things such as the simplification things that I talked about; standardized forms, simplifying the system.

Malpractice reform will take cost out of the system, hopefully getting physicians no longer to have to practice defensive medicine. I think we can take tremendous cost out of the program. It is there for the taking. Look at what we pay versus what other people pay and you can see the huge gap there and in reality we should be able to bring down the cost of health care. I don't think there is any question about that.

Mr. MCKEON. I have a doctor in my district that represents several health care providers, HMOs, PPOs. They have about 75,000 patients and they can provide health care for—it works out about $85 a month. The insurance companies come to them and they are selling—their costs are capitated, and they provide them full coverage for that amount.

They have been driving costs down in our area by doing this through the market. But they are bound by some of the restrictions that they have. In our plan we have a program to allow companies to do that; to not be precluded where they can go directly to the source rather than having to go through the insurance company to pay that extra 20, 25 percent that is tacked on to the top of that premium by the insurance company.

You know, I really like the idea of simplification, but a lot of these forms that we have were put into place one by one to overcome fraud and abuse. Going to one form, what will we do about the fraud and abuse? We are going to have to look at that because that is one of the ways where we are going to cut costs. How do you propose doing that with that simple form?

Mr. BOWLES. I will have to let Dr. Thorpe address that, but let me tell you, you can do that because I have done it. When I came to the SBA I had heard over and over again, and I am sure you did from your private sector experience, gosh, have you seen the number of forms that you have to fill in to borrow from the SBA? The bureaucracy is incredible.

Just on Monday of last week, the President allowed me to begin to test market a form to borrow funds from the SBA in amounts of less than $50,000. We have taken—it used to be the forms were this thick, literally, to borrow from the SBA. We have taken it down to one single sheet of paper.

Mr. MCKEON. Can you send me one of those? I would love to see it.

Mr. BOWLES. Sure. We are test marketing it in San Antonio and in Houston. If it works as well as we think, we will carry it throughout Region six, Texas, and then nationwide.

Yes, we do have some marginal risks—there of people gaming the situation, of fraud and abuse—but it is at the very margin. Truly from my lending experience, I don't know of anything that we are missing, but when you take your forms from here to here, you don't pick up some risks. But I think it is marginal in terms of reward that the small business people will get.

Mr. THORPE. The forms are critical because it provides an easier way to monitor gaming the system. But I think in addition to that what is fundamental in this is changing the financial incentives in the system. You think of a health plan where there are no limits or risks associated with fraud and abuse, because to the extent that there is fraud and abuse, a health plan can pass those higher costs to businesses and individuals and there is no substantial penalty.

By changing the financial incentive so that health care plans have to do a better job of monitoring what goes on with respect to coding patterns and within their plans, you have changed the financial incentives in the system and made it incumbent on health plans to make sure that fraud and abuse in the private sector, having a private monitoring system, are minimized. I think that both provide a capability for health plans to monitor through a single simplified claims form and changes the financial incentives. Where in today's market increased costs can be passed on, that will no longer be the case.

Mr. BOWLES. By making one of the things that the regional alliances will be able to do is provide the purchaser of health care information on the quality and cost of the plans and that kind of information will be invaluable. You will be able to make an informed choice for the first time ever as to where you want to get your health care. It is a big, big change.

Chairman WILLIAMS. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I just have one question.

In looking at the panel following you, some of the testimony that is coming, one of the frustrations I have is dealing with small businesses who either up until now because of the cost, they don't provide insurance for their employees or in some cases—and there is testimony in a few minutes we will hear that a restaurant pays 25 percent of the premiums now for an employee. And obviously under the President's plan, that will go up to 80 percent. And the testimony talks about the increase would go to $120,000 from $23,000. That is going up to the 75 percent and maybe a little more.

How do we as, you know, Members of Congress talk to—and although this is a pretty large small business, I am talking about the three to four employees that a lot of places have, that maybe pay a smaller percentage or maybe none at all of health care.

Mr. BOWLES. Congressman, this is a subject that I addressed a little bit. But I stated clearly that all businesses do not win under some plan. If you do have a large number of low-paid employees and you are only covering a very small portion, then clearly you will pay more.

But if you take your example of a company that only has three or four employees and they are paying them roughly minimum wage employees, you would find that if you do the appropriate arithmetic because of the caps and subsidies that are built into the plan, that that small business will be able to offer its employees real insurance, comprehensive insurance, not a bare bones plan, not something that has a huge deductible, but real insurance at a cost of less than a dollar a day.

That is the way that the arithmetic works. That is the case. And that is something I believe they can afford. And if I didn't believe they could afford it, I truly wouldn't be for it. And it is not just the costs. Over a period of time, the costs, because of the way that costs have escalated, by being able to hold down those costs as we go forward, almost all businesses save long term as you get the cost of health care under control.

Mr. GREEN. Which brings up the other question about the subsidies for that small business that is proposed.

In one of the proposals I heard, a Senator said all we need to do is take out the $65 for medicare, and again there is no method except maybe for a payroll tax for medicare to pay for that. And the administration has costed that out compared to this plan as compared to just expanding the medicare program to include everyone and paying for it by a payroll tax.

Can you tell the extent that you believe that the plan that we are considering from the President will actually be lower than doing that? Because we have to pay for that somewhere just like we pay for medicare now.

Mr. BOWLES. Are you asking me if I believe that the arithmetic works? Yes.

Mr. GREEN. Thank you. Thank you, Mr. Chairman.

Chairman WILLIAMS. Mr. Administrator, thank you very much for being with us. And, Ken Thorpe, I thank you as well. We very much appreciate you coming back to be with us and we appreciate your offer to help us, and we thank you for answering our questions. Also, Administrator Bowles, we appreciate you taking the

time to be with us and we appreciate your understanding of this divisive from the standpoint of a small business person.

Mr. BOWLES. Thank you, sir.

Mr. THORPE. Thank you very much.

Chairman WILLIAMS. I am going to ask our five panel members to come forward now.

Our first witness on this panel is Mr. George Moehrle, President of Moehrle Masonry, which is located in Frederick, Maryland. Mr. Moehrle, thank you for being with us.

STATEMENTS OF GEORGE MOEHRLE, PRESIDENT, GEORGE MOEHRLE MASONRY, INC., FREDERICK, MARYLAND; WILLIAM R. CONNOR, DIRECTOR OF BENEFITS, MEAD CORPORATION; DENNIS A. MEHRINGER, SECRETARY-TREASURER, VELA & MEHRINGER, INC., PASADENA, CALIFORNIA; DENISE MARIE FUGO, OWNER, SAMMY'S, CLEVELAND, OHIO; AND JEANETTE C. PREAR, PRESIDENT AND CEO, DAY-MED HEALTH MAINTENANCE PLAN, INC., DAYTON, OHIO

Mr. MOEHRLE. Thank you. I am George Moehrle and I live in Frederick, Maryland where I operate a masonry contracting business. I work as primarily that of constructing new commercial buildings out of brick and block.

The company was founded in December of 1985. I am also a bricklayer by trade and for the 13 years I have worked open shop in the trade prior to starting the business. I was never once covered by health insurance by any of the employers I worked with, nor did I have an opportunity to buy into an employer-sponsored plan.

So when I started the company, one of the first things I did was initiate health insurance as a fringe benefit. The company paid 100 percent and each employee had the burden of covering their dependents. The original hope was that as the company grew strong we could extend benefits to dependents, as well. That never happened.

What did happen is that in the first year our rates went up 15 percent, even after we cut quite a few of the benefits that we had. And in the second year our insurer, an A-plus best-rated firm, citing the AIDS crisis, pulled out of the market so we were left scrambling to find a new carrier. I remember thinking at first that there should be no problem. We were a good risk.

Our loss to premium expenses were only 5 percent and I figured that most anyone would want to pick us up. What I came to find out was that many insurers wanted nothing to do with a small masonry company and we had to go out and hussle to find another carrier to pick us up. We had to reduce our benefits and accept a 35 percent increase in our premiums.

On about this time, the 1980s were drawing to a close and the expansion in terms of commercial construction in the Washington market was starting to shrink. And I was finding that the cost of health insurance added to the labor costs that I already bore in a marketplace where most of my competitors did not cover their workers. It was becoming a significant part of my either winning or losing a contract.

This experience causes a lot of uncertainty. Some of it is based on what you fear will happen to you. And so it becomes that much more difficult to anticipate what your costs are going to be in coming years as you pick up a contract and say you pick it up in January and have to renegotiate with your insurance carrier in April.

What I came to wonder was whether or not this system itself actually worked. I had to be concerned about the fact that at that time my employees were healthy and the economy was strong, but the economy likely was going to turn down and if one of my employees became sick, I might find myself not being able to cover my employee any longer and I, frankly, had to ask myself was this really a "risk spreading" insurance system or was it a sort of strange, morbid lottery where the first person who gets sick wins.

In addition, I wondered what sense it made for countless thousands of businesses whose specialty is not health care to bear the enormous cost of administering their health insurance plans from 1,200 insurers who were protected from antitrust law. I find that galling. And with whom we small businesses had little or no bargaining power.

I should tell you that I, too, Ms. Woolsey, am a supporter of the single-payer approach, but I would wholeheartedly support the Clinton plan because it, I think, it addresses the core concerns of small businesses, and I would have to point out that I have to give them credit for a great deal of thoughtfulness, and I admire their political guts for forwarding it in a political environment where many of us automatically shun the idea of a government helping to solve the problems that we all face.

One thing that I would like to point out that was not discussed here and that is that in all the plans that have thus far been offered, we seem to want to rely on building on the current system. Ms. Woolsey, you are correct. This system doesn't work. And I understand the political realities of having to try to build up the system we have, but one glaring problem seems to strike me is that we are relying on a payroll tax or a premium to pay for it. That basically amounts to being a tax on jobs.

My fear here is that we are going to put ourselves in a position where we basically price those jobs out of the marketplace, vis-a-vis capital, and my view is that we should pay for this system as any public good like education or police and fire protection through a progressive income tax primarily because that spreads the load across labor and capital in the marketplace.

That is basically my point of view generally on the system.

Chairman WILLIAMS. Thank you very much.

Our next witness is the Director of Benefits for the Mead Corporation, Mr. William Connor.

Mr. Connor, thanks for being with us.

Mr. CONNOR. Thank you. Mr. Chairman and members of the subcommittee, I am William Connor, and I am Director of Benefits for the Mead Corporation, headquartered in Canton, Ohio. I appear here today on behalf of the Association of Private Pension and Welfare Plans, or the APPWP.

My company, the Mead Corporation, is a large forest products and electronic publishing company. We have approximately 20,000 employees in 39 different States. While you probably know us best

through our Nexus or Lexus research services, most of our business is centered in the forest products industry. I would like to use my formal time to address just two issues.

The first issue is why I believe that the employers must continue to play the primary role in purchasing health care coverage for employees and how we believe aspects of the President's plan would end that role.

And the second major issue I want to discuss is the need for national uniformity in any health care reform. It is true that there are a few companies seeking to end their role in providing health insurance for their employees, but a large number of other employers, including Mead and APPWP's members, believe that we bring value to the health care system that serves our employees and their families. We believe our role must be maintained.

Unfortunately, we believe that the President's proposal essentially eliminates employers from the role of purchasing health care. This function will be taken over by large governmental alliances operated by States.

Employers will be relegated to a role of simply paying for the worker's coverage without the ability to participate in the purchase of that coverage. Much has been made of large employers being able to join large alliances under which we could continue to operate our own health care benefit program; however, we think that few employers, and my prediction is that no employers, would view this as a viable option.

The realities of the marketplace and the dual set of rules that would apply to corporate versus regional alliances will make corporate alliances an unrealistic option. This is because there are serious disincentives to the employers to set one up.

The 1 percent payroll tax at Mead it would result in an immediate increase in our current health care cost of 9 percent. Employers without the regional alliances would represent a small percent of the market. This would eliminate the bargaining leverage needed to negotiate cost saving and quality enhancement initiatives.

We believe that the result of removing employers from the purchasing of health care and limiting our role only to paying for it will result in costs going up and quality coming down. Costs would go up because large employers have led the effort to build a more efficient health care system which is now achieving a measure of success.

A State-run alliance is no substitute for multiple employers actively purchasing health care with their own money on the line. The administration cites employer-sponsored health plans as part of his argument for proposed regional alliances. The administration is correct that health care costs have begun to come down, but these results are not due to the arrangements similar to the purchasing alliances.

Rather, these work because of the wide range of aggressive cost control and quality improvement initiatives undertaken by active innovative employers purchasing health care. We also think that the quality of care will come down if employers are eliminated from the system.

Many employers seeking to control costs have focused on improving quality. In contrast, we believe that government administrators

are much more likely to focus their attention on meeting their budgets. Medicare is a good example of this.

The second and another major issue that I wish to address is the need for national uniformity. It is essential that multi-State employers have as much uniformity as possible in providing health care to their employees. Several key elements in the President's plan recognizes this crucial need such as preventing States from altering the benefit package on a provision-by-provision basis.

But the Health Security Act also contains other provisions that would ultimately destroy national uniformity. This includes allowing States to require all employers to participate in their single-payer plan and preventing States to add or to change the benefits from the national package. A loss of national uniformity will not only result in undue administrative expense and confusion for multi-State employers, it will also cause tremendous disruption in employee relations as workers in one State receive a better deal than coworkers in another States.

In conclusion, Madam Chair, legislation can be crafted which we believe will meet or exceed every goal that President Clinton has set for health care reform while producing a better system than we have today. We have developed detailed proposals to improve our health care system through employment-based policies.

APPWB and my company would be pleased to work with the subcommittee and the staff to develop detailed proposals that would address everyone's concerns.

[The prepared statement of Mr. Connor follows:]

WILLIAM R. CONNOR

I. Introduction

Mr. Chairman, members of the Subcommittee, I am William Connor, Director of Benefits of The Mead Corporation. On behalf of the Association of Private Pension and Welfare Plans (APPWP), I am pleased to offer comments on the President's health reform proposal.

APPWP, like The Mead Corporation, firmly believes that health reform legislation should build on rather than dismantle employment-based health benefits. The current employment-based system is not perfect. It would be improved by well-designed reform legislation. However, the employment-based system provides the strongest foundation for achieving universal coverage, cost containment and quality improvement. Eliminating rather than strengthening employers' role as active purchasers of health benefits would lead to a less affordable and lower quality health care system for an increasing number of Americans.

For practical purposes, we believe the Clinton Administration's Health Security Act would eliminate employment-based health benefits. While employers would have an increased responsibility to pay for workers' health benefits, their ability to control costs and improve quality would be eliminated. As a result, we have serious reservations about the Administration plan as it is currently drafted. We reach this conclusion despite the many positive aspects of the President's plan.

APPWP's reservations about the current version of the Health Security Act should not be mistaken as opposition to health reform. In December 1992 APPWP adopted a comprehensive health reform plan which would achieve universal coverage, hold down costs and improve quality through a reformed employment-based system. Critically, we define an employment-based system as one in which employers are active purchasers of health benefits, rather than simply passive payers of assessments set by the government.

Instead of focusing on APPWP's proposal this morning, I will explain a few of our key concerns about the Clinton plan. These include (1) the elimination of employers as purchasers of health benefits, (2) state flexibility, and (3) creation of barriers to market competition and effective managed care plans.

I would like to reiterate the context for APPWP's concerns. President Clinton's leadership has irreversibly set the country down the road toward passage of a comprehensive health reform bill. Many elements of the President's plan should be included in the bill that passes. However, the President's proposal as currently drafted should not be passed without major changes.

Before addressing our specific concerns, I will take a moment to explain what the Mead Corporation has done with its health benefits program. We are taking an innovative approach to managed care under which our employees are not restricted to a closed list of

providers. Rather, employees may choose any primary care physician they want to manage their care. As long as that care, including visits to specialists, hospitalization, etc., is coordinated by the primary care physician, full benefits are provided. We believe that the primary care physician's normal prudent approach to practicing medicine will result in better care for our employees at lower cost.

The Mead Corporation also operates (1) special programs to manage mental health, chemical dependency, and prescription drugs and (2) some traditional forms of managed care with restricted provider panels.

II. Elimination of Employers as Health Benefit Purchasers

We believe the Health Security Act would eliminate virtually all employers from their current role in purchasing health benefits offered to their employees. Employers' purchasing role would be taken over by "regional alliances" which would be operated, directly or indirectly, by state governments. Eliminating employers from their role in purchasing health benefits is the Health Security Act's fundamental flaw, and is likely to result in increased costs, increased selection effects in the insurance market, and lower quality health care.

The Administration cites examples of employer-sponsored health benefit plans that have achieved positive results in arguing that its proposal for regional alliances "builds on proven models." The Administration is correct to point out that employer-sponsored plans have achieved positive results, but these results are not attributable to arrangements that are similar to regional alliances. The employer-sponsored plans which the Administration identifies as proven models work well because employers are involved as active purchasers of health benefits.

A. Mechanisms Used to Eliminate Employers' Role

The Administration's plan uses several mechanisms to eliminate employers as purchasers of health benefits. First, all private employers with fewer than 5000 full-time employees and all public employers (regardless of size) would be required to purchase health benefits through a regional alliance. These employers, accounting for the vast majority of the workforce, would play no direct role in purchasing health benefits.

Private firms with more than 5,000 full-time workers would face overwhelming disincentives if they attempted to form a corporate alliance. A partial list of these disincentives includes the following items:

• **Size and Power of Regional Alliances.** Employers outside of regional alliances would represent, at most, a few percent of the

market. This would deprive them of the bargaining leverage needed to negotiate cost-saving and quality-enhancing initiatives that require health plans to change the way they do business. Additionally, large employers would be exposed to cost-shifting by regional alliances and Medicare.

• **Discriminatory Taxes on Employers Forming Corporate Alliances.** Employers forming regional alliances would be required to pay a 1% payroll tax. This tax discriminates against corporate alliances. Even if some of the costs this tax is intended to cover are built into regional alliance premiums, regional alliance premiums are capped as a percentage of payroll while corporate alliance premiums are not. Additionally, when costs are built into premiums a portion is paid directly by workers. The entire payroll tax is paid directly by employers. At Mead, this would result in an immediate increase over our current health care costs of more than 9%.

APPWP supports broad-based financing to cover the cost of needed and efficiently operated public programs. To date, the case has not been made that a 1% payroll tax on corporate alliances meets these criteria.

• **Rules Reducing Employers' Ability to Manage Costs.** Large employers' limited purchasing power would be further diluted by the requirement that they offer at least three health plans. Moreover, large employers would be constrained from selecting three highly efficient plans by the requirement that they offer at least one fee-for-service or point-of-service plan. These limits on cost management would discourage large employers from choosing the corporate alliance option.

• **Unavailability of Public Subsidies to Corporate Alliances.** Employers forming corporate alliances, unlike those joining regional alliances, would not be eligible for government subsidies to cap their health expenditures as a percent of payroll. Additionally, employers forming corporate alliances would be responsible for providing low wage workers with enhanced premium subsidies. Government subsidies would cover this cost for employers joining regional alliances.

B. Consequences of Eliminating Employers from Health Benefits Purchasing

1. Increased Costs. Employers are driving the ongoing revolution in the organization of health care delivery systems and the health care market. There is increasing evidence that these employer-led efforts are beginning to payoff. For instance, a recent study of employer-sponsored health plans by KPMG Peat Marwick indicates that health cost increases, while still too high, are slowing. Employers are limiting cost increases even though Medicaid and Medicare cost-shifting adds several percentage points to the annual

increase in employers' health benefit costs.

Under the Health Security Act employers would have neither the incentive nor the means to influence health costs, since they would be limited to paying bills wholly determined by others. As a result, the employer-generated cost containment pressure which is beginning to achieve some success would be eliminated.

Multiple purchasers are required to successfully control costs. By eliminating employers as purchasers, the Health Security Act also eliminates this essential source of innovation. Different employers have emphasized different approaches, e.g., collective purchasing, negotiating quality standards with health plans, restructuring premium subsidies to employees, new data technologies, and requiring health plans to move toward integrated delivery systems. As mentioned previously, Mead has adopted a highly innovative approach to purchasing care through primary care physicians.

A state-run regional alliance is no substitute for multiple employers actively purchasing health benefits. No single entity could replicate the range of cost control and quality improvement initiatives undertaken by multiple active purchasers. **Additionally, a government entity is less likely than private purchasers to make the tough choices needed to cut costs and improve quality, since doing so could generate intense political opposition.** For instance, the Health Security Act would require fee-for-service offerings, even though many employers are moving away from such options as an inefficient method of purchasing health care.

2. Selection Effects. The Health Security Act would shift over 130 million Americans from group choice of health plan (entire group enrolls in one plan, or the group offers a limited selection of plans from which its members choose) to individual choice among all plans offered through a regional alliance. This could have the unintended consequence of increasing risk selection among health plans, while hampering efforts to achieve risk adjustment among plans.

3. Lower Quality Care. Many employers seeking to contain costs have focused on improving quality. For instance, the Minnesota Business Health Care Action Group (a collective purchasing initiative by 21 employers covering over 200,000 lives), the Digital Equipment Corporation, and the Cincinnati Payer Initiative (General Electric, Procter and Gamble, Kroger and Cincinnati Bell) are aggressively implementing leading-edge quality improvement strategies.

Government administrators are likely to focus almost exclusively on meeting their budget through reimbursement rules, to the detriment of quality improvement. This clearly has been the case in

Medicare, where quality is a much lower priority than administering price control schemes.

III. State Flexibility

Nationally uniform rules establishing a competitive health care market are essential to the private sector's ability to cut costs and improve quality. National uniformity is critical to cooperative labor-management relations in multistate firms and to multistate employers' ability to efficiently administer health benefits. We also support national uniformity in light of our disappointing experience with laws in many states that have been hostile to the private sector's cost control initiatives. Finally, millions of Americans cross state borders to obtain jobs and/or health care. State-by-state health system rules could create daunting problems in the nation's many interstate health care and labor markets.

Allowing states to vary health system rules governing the large percentage of the market made up of smaller employers creates nearly as many problems as allowing states to regulate large, multistate employer plans. Rules governing the majority of the market will define the range of possibilities available to multistate employers.

Several elements of the Administration's plan appropriately recognize the need for national uniformity. For instance, one provision designates the Secretary of Labor rather than the states as responsible for enforcing corporate alliance standards. Additionally, the Health Security Act does not authorize state waivers from federal standards on a provision-by-provision basis. These provisions make good sense.

Unfortunately, the Health Security Act also includes provisions which would destroy national uniformity. These provisions include the following items:

• **Single Payer Option for All or Part of a State.** States could require all employers to participate in a single payer system. The single payer system could cover all or part of a state. This could lead to inconsistent treatment of workers in different states, greatly complicating bargaining and pressuring employers to make available to all employees the most permissive arrangements available to any of their employees.

Additionally, it is not clear how employers responsible for organizing network-based coverage in one state could provide coverage and control costs for workers who receive care in an adjoining state if the adjoining state elects the single payer option. Similarly, provider networks in a non-single payer state could be forced to operate under different rules and incentives when serving patients covered by a single payer state. This will

drive up costs and increase administrative complexity for all payers. All of these problems are magnified if portions of states become single payer areas.

The state single payer option creates an additional problem for multistate employers. Employees residing in single payer states (or areas) would not count for purposes of determining whether an employer is large enough to form a corporate alliance. An employer doing an excellent job of managing benefits could be forced into a regional alliance if a single state chooses the single payer option.

• **State Administration of New ERISA Title.** The Health Security Act would create a state role in adjudicating participants' claims against corporate alliances. We have grave concerns about the expansion of remedies for claims denial. These concerns are compounded by the numerous differing standards governing claims denial likely to arise out of state adjudication. While appeal is available to a federal agency and the federal courts, cost and other practical factors prevent appeals from resolving problems related to state-by-state claims adjudication.

• **State-Determined Fee Schedules.** The Health Security Act mandates that each fee-for-service plan (and fee-for-service portion of network plans), including plans which corporate alliances would be required to offer, pay providers according to a fee schedule established by regional alliances. The incentives driving regional alliances in setting fee schedules could lead to more generous reimbursement than a corporate alliance would find to be justified.

• **Mandating Additional Benefits.** States are permitted to add benefits to the national package, so long as they do not rely on funds provided under the Health Security Act. Workers in one state are likely to seek the benefits received by their co-workers in other states, particularly if their employer is taxed to pay for the additional benefits.

• **Mandated Contracting with Essential Community Providers.** States can require corporate alliance health plans (as well as regional alliance health plans) to contract with providers in underserved areas designated as "essential community providers" by the federal government. Government has a legitimate interest in assuring that health plans offer enrollees appropriate geographic access. However, this particular approach could insulate providers from market pressure to improve cost and quality performance, and deny corporate alliances the opportunity to manage costs as effectively as possible. Health plans should be accountable for providing appropriate access to care, not care from state-specified providers.

Allowing states to require health plans to contract with specified providers also raises serious conflict of interest problems. Many

essential community providers may be state-sponsored institutions.

IV. Barriers to Competition and Effective Managed Care Plans

The Health Security Act attempts to create a framework that will stimulate price and quality competition among health plans and the development of increasingly effective managed care plans. APPWP agrees with this framework and with several of the policies adopted to promote competition and effective managed care (e.g, preemption of anti-managed care and anti-managed pharmaceutical laws, expanded role for mid-level practitioners). Nonetheless, we are concerned that several of the Act's provisions are inconsistent with the framework. A partial list of items which could tend to reduce competition and the effectiveness of managed care plans follows:

• **Eliminating Group Choice of Health Plans.** Competition is fostered by multiple group purchasers (i.e., employers) negotiating and selectively contracting with health plans. As already discussed, group purchasing would be eliminated by the Health Security Act.

Since group purchasers would be eliminated, competition is restricted to encouraging individuals to select lower cost health plans from the large number of plans most regional alliances would offer. Giving individuals appropriate incentives to select efficient health plans will promote cost containment, and should be a key approach included in health reform legislation. However, it may be unrealistic to expect individual choice among a large number of health plans, including high cost plans, to carry the full burden of cost containment.

"Structured choice," in which a group purchaser offers a limited number of plans (which might not include high cost options) from which consumers with appropriate incentives choose their coverage, may be more likely to control costs. Notably, many employers with a record of successful cost control--including employers whose experience the Administration cites as demonstrating the value of the regional alliance concept--have moved away from unstructured choice among a large number of health plans to structured choice among a limited number of plans.

• **Weakness of Incentives for Individuals to Choose Efficient Health Plans.** The concept of giving individuals a financial incentive to choose an efficient health plan is sound. However, the Health Security Act's specific rules governing the premium subsidy individuals receive may not create a strong enough incentive to achieve the desired level of cost control.

First, the minimum subsidy all individuals receive--80% of the average weighted premium in an alliance--is generous. Depending on various factors which determine the subsidy's dollar value within each alliance, an individual's share of premiums for even an

expensive plan might be relatively small. Note that the Health Security Act's minimum premium subsidy may exceed the premium subsidy many workers now receive. Workers receiving an increased premium subsidy as a result of the Health Security Act are unlikely to be strongly motivated to switch their coverage to more efficient plans.

Second, under the Health Security Act, employer premium subsidies above the required minimum continue to be excluded from employee income for tax purposes. This gives employees an incentive to seek an additional employer premium subsidy. This incentive would be reinforced in firms which realize savings by moving into community-rated coverage and receiving other subsidies. Their workers may expect to obtain a share of these savings through employer payment of workers' share of premiums.

Employers who pay for workers' share of premiums must make the same contribution for all employees, and provide a cash rebate to an employee if the contribution exceeds the total premium of the health plan the employee selects. The rebate would be taxable income to the employee. Overall, this structure encourages employees to seek a high premium subsidy as part of their overall compensation, since employees using it to pay premiums would receive tax advantages while those electing a rebate would not be in a different position than at present.

• **Premium Caps.** The Administration's premium cap proposal raises numerous critically important issues requiring careful analysis. Here, I raise only two of these issues which bear on whether the Health Security Act would create market competition that will control costs.

First, a health plan with a rate of increase above the regional alliance-wide permitted rate of increase in a given year could be penalized, even if it is a low cost plan. More expensive plans which hold down their rate of increase would not be penalized. This creates an incentive for a health plan to raise premiums by the maximum permissible amount each year even if it could make do with less, in order to create a cushion in the event that it must reduce its rate of increase in future years to avoid a financial penalty. Similarly, health plans would have an incentive to set a higher base cost than they otherwise might in the first year, in order to build a cushion against future penalties triggered by other plans' high costs driving down every plan's permitted rate of increase.

Second, regional alliances actively negotiate premiums with each health plan they offer. Whether each plan stays within budget is dependent on the premiums charged by every other plan. As a result, a regional alliance's bargaining strategy and skill could create advantages and disadvantages for particular plans unrelated to the plans' ability to control costs and improve quality. For

instance, if a regional alliance faced political pressure to keep an inefficient plan alive, it could do so by forcing more efficient plans to reduce their premiums.

• **Rigid Cost-Sharing Rules.** The Health Security Act includes three options for cost-sharing, with permissible cost-sharing under each option defined in detail. Reasonable cost-sharing limits are an appropriate consumer protection. However, freezing cost-sharing in place through detailed specification of cost-sharing will hamper the innovate use of cost-sharing to achieve cost containment. For instance, network-based plans which currently use nominal cost-sharing may wish to experiment with intermediate levels of cost-sharing, but would be confined to either nominal or high levels. Similarly, employers and health plans might wish to experiment with income-related cost-sharing in order to give highly compensated workers the same financial incentives as lower compensated workers, but would not be permitted to do so.

Additionally, the Health Security Act's cost-sharing rules for use of non-network providers may create too small an economic incentive to encourage use of network providers.

• **Mandated Use of Specific Providers.** The Health Security Act grants preferred status to specified providers, including "essential community providers" and academic health centers. Health plans would be required to do business with these providers, regardless of their efficiency or quality. This will reduce pressure on providers to improve their operations, and make it more difficult for health plans to effectively manage their networks' cost and quality.

V. Conclusion

Mr. Chairman, members of the Subcommittee, we are confident that legislation can be crafted which would meet or exceed every goal President Clinton has set for health reform and produce a better employment-based system than we have today. APPWP has already developed detailed proposals which would achieve an improved health care system through employment-based, market-driven policies. APPWP and The Mead Corporation would be pleased to work with the Subcommittee to develop further detailed proposals that will address your concerns and ours.

Mr. Chairman, members of the Subcommittee, I would be pleased to answer any questions you may have.

Ms. WOOLSEY. [presiding] Mr. Mehringer.

Mr. MEHRINGER. Hello, my firm is very small. It was just me in 1990. Then I brought in a partner, and I hired another person and we added health care in February of 1991, $177.40 a month. Now we are sitting here in 1993, just 27 months later from the time I started health care, and it is up to $308 a month; 74 percent increase.

And guess what? None of the people covered in my health care plan have ever had a claim. We haven't gotten one cent of benefit from health care and we pay 74 percent higher premiums.

I am here today because I am in favor of the Clinton health plan. The reason I am in favor is twofold: One is it will save me money. My small business will pay less money than it currently pays by the implementation of the plan as is.

The second is that I am clearly paying for somebody else's claims because we have none. Whose?

I am paying for the other businessman who is not covering his employees and those employees are using emergency rooms at the highest costs and we, the rest of us who are paying premiums, are paying for those people who are using the emergency rooms.

The last item that I want to cover is simply the issue of efficiency. The reason that many of my clients, who are doctors, do not make more money than they do is because they have employees who have to spend their full-time job filling out forms for all the different insurance companies and all the different HMOs and PPOs there are in existence today.

Every year I go to Scripps and I get a physical exam out of my pocket. When I check into Scripps, all they do is scan my health record into their computer on this little card. Every other place I have ever been in my lifetime I have to fill out a bunch of forms.

If electronic filing was mandated throughout the system, everyone would save money at every level of the system. That is all I have to say today.

Thank you.

Ms. WOOLSEY. Thank you.

Next we have Denise Marie Fugo, owner of Sammy's in Cleveland Ohio.

Mrs. FUGO. Thank you. My name is Denise Fugo, and I wanted to thank Mr. Bowles for doing such a great introduction on COSE. I did serve on COSE for eight years, and I would like at the end of my remarks to just add some additional comments to what Mr. Bowles commented on earlier.

I am a restaurant owner. I appreciate the opportunity to be here today to present my views because I have been very alarmed by skyrocketing health care costs and I have been involved in trying to contain those costs. We are all here to find a solution that can be reached for a system in which health care is both affordable and available to people.

But like most restaurateurs, as well as my employees, we are alarmed about a lot of provisions in the Clinton health care reform bill. My husband and myself, we own several restaurants in Cleveland today. Our success has been based on what America is all about: the American dream and the human spirit.

When we started in 1980 we had very little restaurant experience. Both our mothers are Slovak, both our fathers are Italian. So we grew up cooking and with great appreciation for food.

The little restaurant experience we had was mine. I had worked at Burger King for six years in high school and college and I worked as a waitress putting myself through college. We relied on our strength and we relied on our ability to learn on the job. And we did.

Through hard work, lean management, great customers—and we define customers in our organization as the customer who pays the bill, the employee, and the vendor—through great customers and a little luck, we have succeeded and will be very successful when we pay the banks back.

But I would like to point out that even though we have been successful and we are entering our 14th year of business, we are an undercapitalized business. And I have heard comments in the administration that they can't be worried about the small, undercapitalized business.

Well, I am living proof that you can build up to 95 employees and still remain undercapitalized in the eyes of your bank and your insurance company.

For three years my husband and I worked two jobs. We both had daytime jobs, and at night we renovated a home in Chicago. We took a $40,000 profit out of that house before tax, moved back to Cleveland, moved in with relatives and started a business in 1980 with 11 employees.

I would like to point out that for two years we took no salary and I would not have been able to start this business if at the front door—I was able to create the jobs, but providing health care on top of those jobs. Honestly, it was very lean and I am not sure it would have worked.

Today we have four fine dining establishments, banquet rooms and off-premise catering. We employ 95 full-time employees, and we peaked at 230 part-time employees when we recently catered a special event under a tent. These are good jobs.

Our pricing is at the high end of the market, so our tipped people do well. Our catering people make from $5-$14 an hour. Most of them are in the $8-$10 range. And many of our employees make more money than the steelworkers that still exist in Cleveland; there are just a few.

I have worked with thousands of people in the 13 years that I have been in business and the one thing that I have watched is the development of self-esteem when you can provide employment for people. Now we have learned through the years the hard way that the restaurant industry is unforgivingly competitive.

In Cleveland one of my primary meat vendors is closing his doors and putting 70 people out of work. You must be disciplined, focused and lean in the way that you operate.

We have learned that government can be our greatest competitor. What concerns me about a lot of this plan that I have are that my biggest expenses today are in areas where the government is already involved. Utilities, which in Ohio are reviewed by a public commission, continue to increase without relationship to my sales. My State worker's compensation premiums which you run through

the State of Ohio have been increasing from 20 to 35 percent a year.

Even though we are struggling through a recession the government is asking more of us today. And what I have provided for all of you is a little piece of paper that shows you what an organization has to comply with in our industry, which is the food business. I hope you get a chance to take a look at it.

I don't pretend to be an economist, and I am not an expert on health care, but I do know my business and my industry. But I do know how to create jobs and most importantly the jobs that I create, create wealth for my family and for my employees' families.

Now I know we operate as an industry on some of the thinnest profit margins in America, so little changes in the American economy have a very large impact on fragile businesses. I know that this year my bank and my insurance company thought we were not profitable enough.

Through the summer, the first six months of the year, I know the government is still revising estimates, the first six months in America were tough on the retail industries in America. March was one of the worst on record.

I was losing $150,000 through June of this year, and my bank and my insurance company said if you guys want us to be here for you next year you better make some changes and we did; and you have to make tough choices. I did have to lay three people off this summer. I did have to cut my payroll expenses by $75,000.

My bank has told me to provide a minimum $50,000 profit this year. And we know that competition for the restaurant business is intense and largely driven by price. I know that my industry is extremely labor intensive but that is good for employment. And we rely heavily on part-time and entry level workers.

I also know that employer mandates make for wrong-headed policy if your goal is to get me to create more jobs. Now I have provided health insurance for my employees for the last 10 years, and like these two other gentlemen, I did have insurance in the first two years—I was on the COSE board for three years before I bought their health insurance, but after I had experience with 35 percent change one year, and being dropped because you have to send someone to alcohol rehabilitation or something, then I looked into COSE and the reason that it has had the success that it has had is because the business owners—the money goes to two things, the products that you buy or to your people.

We watch those dollars very carefully. And little companies have been able to talk to the big companies, as Mead has been able to, to negotiate an insurance program where our costs have been less than 10 percent, something that we can all live with, for the 10 years that I have been involved.

Now most of the people in my company start as busboys, coat-check people or bartenders.

Chairman WILLIAMS. [presiding] Let me interrupt to tell you that your time has expired, and if you could, please summarize the remaining part of your testimony.

The reason I am doing this is because the buzzers and the lights are indicating that the members are going to have to close this hearing in a few minutes. We do want to hear from our remaining

witness, as well, the members would appreciate an opportunity to ask a couple of questions.

Mrs. FUGO. You had talked in the beginning that you wanted to talk numbers, so I think it is important that we give you an impact.

In our best year, we did $4 million in sales. It has been a struggle to reach that ever since. Last year my health care costs were $23,000.

If we assume that this premium goes into effect, we will use the numbers that have floated around in the industry, that is a 7.9 percent premium. If we include the tip income of my employees, that is $120,000.

I went to my employees and said what should we do? We have two choices. Our choices are—can you cut your product quality? That is sort of a customer franchise, that is why people come to us because of the quality we provide.

And where is the other area? I spend a million-and-a-half on payroll every year. Is there $120,000 that I can cut?

And when I ask my employees should I eliminate jobs or take a pay cut across the board, the people that feel that they are going to be there if there is a layoff say lay off people. But those are the realities. There are no other dollars that are hidden anywhere.

The bank debt is not paid down. Those are the kinds of issues that we face. My experience tells me that the bureaucratic maze that a whole new system will create will only raise prices.

Just a couple things that I look at as a business owner. The cost of a postage stamp has never gone down in my lifetime. The State of Ohio, which manages our worker's compensation program, has not passed an audit in the time I have been in business and now we are going to ask the State of Ohio to get into these health care alliances.

Even though we have lost population for the last four years, there is a tremendous building boom going on in Cleveland adding additional hospital beds. So as a small business owner I would rather keep the focus of trying to make a better system for the people whose money and jobs are at stake, which is myself and the people that work for me.

In summary, COSE's 17 years' experience, it didn't take 17 years for us to get 120,000 people covered under health care. But ideas do take time. And the reality is no program is going to happen overnight because it takes people to implement, it takes people to hammer out each detail.

Allowing businesses and individuals to take 100 percent—if you want everything covered, have everybody deducted against their taxes. Nobody has talked about consumers.

When you start having consumers actually look at their bills, they will question when a hospital charged them $90 for a Tylenol. Get rid of preexisting exclusions. Everyone admitted, that is a problem. Change that. That is a little change.

You have to do something about malpractice. I respect that Congress is three-quarters attorneys, but you have to do something about it. We can't afford to stay in business and litigate, whether you are a doctor or a restaurateur.

Let the consumer see the bill. Let the consumer help the employer save money in this system. You are not going to cost shift.

What you need to do is empower the person that is getting the medical service and let them start asking questions. In Cleveland we ask two questions now: how many procedures of this do you do a year, and what is your mortality rate?

Chairman WILLIAMS. I am going to have to ask you to summarize, or I will go to the next witness.

Mrs. FUGO. Let's make a little success as opposed to making a major blunder which in the end will affect real American's jobs and their livelihoods, and if you have to give them a choice, would you rather have health care or would you rather have a job, their self-esteem, and their answer is that they would rather have the opportunity that allows them to have health care in the future.

Thank you very much.

[The prepared statement of Mrs. Fugo follows:]

Denise Marie Fugo
Proprietor of Sammy's
Cleveland, Ohio
Testimony to the Committee on Education and Labor
subcommittee on Labor-Management Relations

Thank you, Mr. Chairman.

My name is Denise Fugo. I'm a restaurant owner. I appreciate the opportunity to present my views today because I, too, have been alarmed by the skyrocketing costs of health-care and I'm hopeful that some solution can be reached in the search for a system in which health-care is both affordable and available.

But, like most restaurateurs, I am alarmed about some aspects of the Administration's proposal to reform health-care.

My husband and I own several restaurant operations in Cleveland. In a lot of ways our success is affirmation of the American Dream. When we started in 1980 we had very little real restaurant experience. Both our moms are Slovak and both our dads are Italian, so we grew up with a great appreciation for food. What little direct experience we had was mine. I had worked at Burger King for six years through high school and college and had also worked as a waitress.

We knew we would learn on the job.

And we did. Through hard work, lean management, and a little luck, we've succeeded.

We started in 1980 with 11 employees. Today we have four fine dining restaurant facilities, some with catering. We employ 95 full time employees and almost 200 part-time employees. We're extremely proud of this. These are good jobs. Our pricing is at the higher end of the marketplace, so our tipped people do extremely well. Our catering people make from $5-$14 per hour. Most of them are in the $8-$10 range. In fact some of them make more money than steelworkers in my area.

Through the years, we learned the hard way that the restaurant industry is unforgivingly competitive. To succeed you must be disciplined, focused, and extremely lean in the way you operate.

We also learned that the government can be our greatest competitor. Even though we're struggling through a recession, the government continues to ask more and more of us. I have submitted with my testimony a list of all of the federal and state laws I have to comply with in order to run my business. I have also included the appropriate state information for all the members of the subcommittee. As you can see, it's quite an impressive list.

I don't pretend to be an economist or an expert on health-care. But I do know my business and my industry.

I know that we operate on some of the thinnest profit margins in American business.

I know that competition for restaurant business in intense and largely driven by price.

I know that restaurants are extremely labor intensive, and that we rely heavily on part-time and entry-level workers.

And I know that, in this context, employer-mandates make for wrong-headed policy.

We have provided some type of health insurance for employees for about the last 10 years. We care about our employees. My management staff has been with us for years. Most started as busboys, coatcheckers, or bartenders. My head chef started with us as a high school intern. All our employees who work 30 hours a week or more are eligible. The company pays 25 percent of the premiums.

Last year, my health care costs were about $23,000. But under the new proposal, my costs for health care would be more than four-and-a-half times higher

than that. Under the Administration's plan, my health care costs would be $107,866, if tips are not included in the payroll.

This is an increase that would literally wipe out any profit margin in my business. I have two extremely unpleasant choices to absorb the cost. We either raise menu prices or we cut costs in other parts of the business.

Let me tell you: In this market you don't raise prices. Our prices are down considerably since 1989. My newest menu alone cut prices by five percent.

That means we're going to have to cut costs. And that means jobs. I've read that some economists estimate that the new payroll tax will cause job losses of up to 3,000,000. I can easily see why.

On top of this, the additional bureaucratic and financial costs related to employees will force us to put a premium on full-time employees. Part-timers just won't be worth the hassle. Which is too bad for students and mothers and moonlighters, who need to work, but who just can't devote full-time hours. The constraints of employer mandates would build in a bias against them.

At the same time, the responsibility of overseeing health-care compliance will, ironically, force me to add employees -- bookkeepers. I see no other alternative. For one thing, it is prudent business to track and recompute all transactions, just as I do

vendor invoices. For another, how else do we keep track of an employee, who is partly covered by another employer or by a father who has to pay for the kids, and who lives in another state?

Intuition tells me that no number of employees will be adequate to help us through that bureaucratic maze.

Another reason to be skeptical about this health care proposal is that I don't believe the cost projections. I don't believe the government can control costs on anything.

I've read that the U.S. now spends $900 billion per year on health care. I've also read that the Clinton Administration proposes to spend $700 billion annually -- and take care of more people. You don't need hundreds of government analysts to suggest that this doesn't compute.

I, for one, will be spending more than four times more to pay for this program than I would have without it.

For it to work, either the quality of health care will drop to unacceptably low levels, or the government -- which has no profit margin whatsoever -- is going to absorb costs that we cannot even imagine. And when I say the government will absorb these costs, I mean you and me and every U.S. taxpayer.

Which brings me to a frustration that I have felt in trying to assess the impact of this health-care system on my business. I haven't seen any details. Therefore, I can speak only in general terms. One of the reasons our business has been successful is that we never make any major decision without knowing the details. To do otherwise would be irresponsible. I'm hopeful that soon we'll see the details of this proposal. To do otherwise would be more than irresponsible.

The bottom line of my testimony, Mr. Chairman, is that this health care proposal is fraught with problems that scare the daylights out of business people like me.

I don't want yo to think that I'm against finding a way to provide affordable health insurance for everyone who seeks to purchase it. I'm not. I'm hopeful that it can be accomplished in a way that doesn't cause more, perhaps greater, problems along the way.

I have heard some very appealing ideas.

- Let small businesses join together in purchasing groups like COSE, the one I currently belong to.

- Allow all businesses to take a 100 percent tax deduction for health insurance.

- Getting rid of pre-existing exclusions.

- Do something about malpractice.

- Eliminate costly state-mandated health benefits.

- Develop a computerized, standard claims system.

Mr. Chairman, and members of the Committee, I appreciate this opportunity to speak with you this morning. I look forward to working with you as well as members of my congressional delegation so that we can pass something that does the job without unnecessarily devastating my industry. There are, however, many things that can be done about the rising costs in health care that seem to make great sense.

Regulations and Restaurants From A to Z

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FEDERAL

Accessibility to disabled customers (DOJ)
Advance payment of Earned Income Credit (IRS)
Age discrimination (EEOC)
Alcohol excise taxes (IRS)
Annual occupational tax for alcohol-sellers (BATF)
Bloodborne pathogen program for employees who give first-aid (OSHA)
Citizenship-status discrimination (DOJ)
Commuting plans for employers in high-pollution areas (EPA, beginning late 1994)
Continued health benefits for former employees (IRS)
Copyright law and restaurant music (DOJ)
EEO-1 Form (EEOC)
Egg-refrigeration standards (USDA, proposed for 1994)
Exempt managers (DOL)
Family and Medical Leave Act (DOL)
Federal income taxes (IRS)
Federal income-tax withholding for employees (IRS)
FICA payroll taxes (IRS)
FICA payroll taxes on tips (IRS)
FUTA payroll taxes (IRS)
Grease-trap waste disposal (EPA)
Hazard Communication Standard (OSHA)
Health claims and restaurant foods (FDA)
Health benefit plans and the Americans with Disabilities Act (EEOC)
I-9 Form (Employment Eligibility Verification Forms) (INS)
Immigration Reform and Control Act of 1986 (INS)
Independent contractors, reporting of payments to (IRS)
Job application forms, permissible questions (EEOC)
Magnetic media reporting of Forms W-2, 8027 (IRS, SSA)
Material Safety Data Sheets (OSHA)
Meal credit (DOL)
Minimum wage (DOL)
National origin discrimination (EEOC)
Notice to employees of eligibility for Earned Income Credit (IRS)
Nutrient-content claims and restaurant foods (FDA)
Overtime pay rules (DOL)
Payroll-tax deposits (IRS)
Polygraph ban (DOL)
Poster: Equal employment opportunity (EEOC)
Poster: Polygraph (DOL)
Poster: Minimum wage (DOL)
Poster: Family and medical leave (DOL)
Poster: OSHA (OSHA)
Race discrimination (EEOC)
Reasonable accommodation for workers with disabilities (EEOC)
Refrigeration equipment and CFC phase-out (EPA, phaseout by 1996)
Religious discrimination (EEOC)
Restaurant closings, 60 days' advance notice (DOL)
Sex discrimination (EEOC)
Teen labor: Hours restrictions for workers under 16 (DOL)
Teen labor: Occupational restrictions for workers under 18 (DOL)
Tip credit (DOL)
Tip reporting and IRS Form 8027 (IRS)
Tip allocation (IRS)
Tip-income audits (IRS)
Tip pools (DOL)
Uniforms: Deposits, costs, maintenance (DOL)
Veterans' employment rights (DOL)
W-2 Forms (Wage and Tax Statement) (IRS, SSA)
W-4 Forms (Employee's Withholding Allowance Certificate) (IRS)
Workplace phones, hearing-aid compatibility (FCC)

CALIFORNIA

Air Quality Standards
Air Quality Regulations
Alcoholic Beverage License
Alcoholic Beverage Excise Tax
Business License
Cal/OSHA requirements
Child Labor Permits
Conditional Use Permits
Corporate Income Tax
Corporate Organization Fee
Employee Rest Breaks
Entertainment/Dancing Permit
Fictitious Firm Name Statement
Fire Code Compliance
General Property Tax
Hour Restrictions for Minors
Liability Laws
Minimum Wage
Occupational Restrictions for Minors
Overtime Laws
Payment of Wage Law
Personal Income Tax
Poster Requirements
Product Prohibition
Sales & Use Tax
Sales Tax Permit
Sanitation/Food Preparation Regulations
Seller's Permit
Telephone Surcharge
Termination Payment Law
Tip Credit
Unemployment Insurance
Variance Fees
Wage Deductions
Wage Exemption Regulations
Workers' Compensation Insurance
Xero-scape Fee

For more information contact the National Restaurant Association at (202) 331-5900 or the California Restaurant Association at (213) 384-1200.

15 Reasons Restaurateurs Worry About More Government Regulation

Just over the past eight years, restaurants have seen a tremendous increase in the number of federal regulations with which they must comply—and have seen costs and paperwork burdens multiply accordingly.

This page shows 15 changes the U.S. Congress has made just since 1985 in federal laws affecting restaurants. On the other side is a comprehensive list of all the federal and state rules covering restaurateurs.

People who don't run a business are often surprised at the extent of the government's impact on business. Restaurateurs aren't. Regulations have become a fact of daily life in the restaurant industry.

Just becoming familiar with the laws is a daunting task. But consider the costs of complying—in time and in money. And consider the liability if a business owner misses something.

It's no wonder restaurateurs are extremely worried about the proposals Congress is discussing, especially a health-benefits mandate.

1993

⑮ **Business Meal.** Tax deductibility drops to 50% beginning in 1994. (*Omnibus Budget Reconciliation Act of 1993*)

⑭ **Family and Medical Leave.** Employers of 50 or more must provide 12 weeks of unpaid job-protected family or medical leave to employees. (*Family and Medical Leave Act of 1993*)

1991

⑬ **Discrimination.** Employees may bring jury trials and collect money damages in job-bias cases. (*Civil Rights Act of 1991*)

⑫ **Teen Labor.** Maximum per-employee penalties for teen labor violations rise to $10,000, up from $1,000. (*Omnibus Budget Reconciliation Act of 1990*)

⑪ **Alcohol Taxes.** Federal alcohol excise taxes increase 8% for liquor, 100% for beer and 600% for wine. Businesses pay one-time inventory tax. (*Omnibus Budget Reconciliation Act of 1990*)

⑩ **Menu labeling.** Restaurants must meet new federal criteria when they describe foods with such terms as "low-cal" or "light," beginning in 1994. (*Nutrition Labeling and Education Act of 1990*)

1990

⑨ **ADA.** Businesses must take affirmative steps to prevent bias against customers and employees with disabilities, including making facilities more accessible. (*Americans with Disabilities Act of 1990*)

1989

⑧ **Minimum Wage.** Minimum wage rises to $3.80 in 1990 and to $4.25 in 1991. (*Fair Labor Standards Act Amendments of 1989*)

1988

⑦ **Plant Closings.** Employers of 100 or more must give 60 days' advance notice of closings. (*Worker Adjustment and Retraining Notification Act of 1988*)

⑥ **Alcohol-Sellers' Tax.** Businesses selling alcohol must pay special annual tax of $250, up from $54. (*Omnibus Budget Reconciliation Act of 1987*)

1987

⑤ **FICA Tax on Tips.** Restaurateurs must pay FICA taxes on all employee tips, beginning January 1, 1988. (*Omnibus Budget Reconciliation Act of 1987*)

④ **Immigration.** Employers must fill out I-9 forms for all new employees. (*Immigration Reform and Control Act of 1985*)

③ **Section 89.** Employers must prove benefit plans do not discriminate in favor of highly-paid workers. Law repealed in 1989. (*Tax Reform Act of 1986*)

1986

② **Business Meal.** Tax deductibility drops to 80% beginning in 1987. (*Tax Reform Act of 1986*)

1985

① **Continued Health Benefits.** Employers of 20 or more must let former employees and beneficiaries continue buying into health plans for a limited time. (*Consolidated Omnibus Budget Reconciliation Act of 1985*)

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HAWAII

Alcoholic Beverage Tax
Beverage Container Tax
Child Labor Work Permits
Child Labor Laws
Choking Training
Common Victualler's License/Fee
Container Tax
Corporate Organization & Qualification Fees
Corporation Annual Report Fee
Corporation Excise Tax
Fire Code Compliance
General Excise Tax
Hour Restrictions for Employees Under 16
Hour Restrictions for Employees 16 & 17 years old
Liability Laws
Liquor License/Fee
Mandatory Rest Breaks
Minimum Wage Laws
Miscellaneous Business Licensing Fees
Noise Compliance
Occupational Restrictions for Minors
Payment of Wage Laws
Personal Income Tax
Poster Requirements
Pre-Paid Health Care Law/Regulations
Property Tax
Record-keeping Requirements/Wage Reporting
Room Occupancy Tax
Sanitation/Food Preparation Regulations
Temporary Disability Insurance
Termination Payment Laws
Unemployment Insurance
Wage Deduction Laws
Wage Exemption Regulations
Workers' Compensation Insurance
Zoning

For more information contact the National Restaurant Association at (202) 331-5900 or the Hawaii Restaurant Association at (808) 536-9105.

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Corporation Excise Tax
Corporate Organization and Qualification Fees
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Sales and Use Tax
Sanitation/Food Preparation Regulations
Soft Drink Tax (local)
Smoking Laws
Tip Credit Law
Unemployment Insurance
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Wage Deduction Laws
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MICHIGAN

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MINNESOTA

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Business Activity Fee
Business Licensing Fees
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Child Labor Work Permits
Corporate Filing Fee
Corporate Income Tax
Corporation Annual Report Fee
Discrimination Laws
Dram Shop Liability
Drinking Water Regulations
Employee Leave Law
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Liquor License/Fee
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Milk Pricing
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Property Tax
Recordkeeping Requirements/Wage Reporting
Restaurant License
Room Occupancy Tax
Sales and Use Tax (state and local)
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Smoking Regulations
Sunday Liquor License/Fee
Termination Payment Law
Third Party Liquor Liability
Tip Reporting Law
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MONTANA

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Corporate Organization and Qualification Fees
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Fire Code Compliance
Liability Laws
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Room Occupancy Tax
Sales Tax
Sanitation/Food Preparation Regulations, License and Fees
Sunday Liquor Sales Regulations
Termination Payment Law
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NEBRASKA

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Meals Tax
Milk Permit/Fee
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Poster Requirements
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NEW JERSEY

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Child Labor Employment Certificate
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DEPE Environmental Regulations
Disability Insurance
Disability Tax
Fire Code Compliance
Fire Safety Tax
Food License
Highway Access Regulations
Hour Restrictions for Employees under 16
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Liability Laws
Liquor License/Fee
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Mandatory Rest Breaks
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Minimum Wage Laws
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NEW YORK

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Child Labor Work Permits
Consumer Affairs Permits/Regulation
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NORTH CAROLINA

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Corporate Organization and Qualification Fees
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Entertainment License Fee (state/local licenses)
Fire Code Compliance
Hour Restrictions for Employees under 16
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Tip Credit Law
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Child Labor Work Permits
Choking Training
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Franchise Tax
Hour Restrictions for Employees under 16
Liquor License/Fee
Mandatory Rest Breaks (minors)
Minimum Wage Laws
Occupational Restrictions for Minors
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Room Occupancy Tax
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Vendor's License/Fee
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PENNSYLVANIA

Alcoholic Beverage Tax
Bakery License/Fee
Business Licensing Fees
Child Labor Laws
Child Labor Work Permits
Container Tax
Corporation Excise Tax
Corporate Organization and Qualification Fees
Egg Refrigeration Law
Fire and Panic Safety Code Compliance
Frozen Dessert License Fee
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Hour Restrictions for Employees 16 & 17 years old
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Milk Permit/Fee
Minimum Wage Laws
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Payment of Wage Laws
Personal Income Tax
Poster Requirements
Property Tax
Recordkeeping Requirements/Wage Reporting
Restaurant Eating and Drinking Place License
Room Occupancy Tax
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Sanitation/Food Preparation Regulations
State Bureau of Occupational and Industrial Safety Regulations
Sunday Liquor License/Fee
Termination Payment Law
Tip Credit Law
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Unemployment Tax
Wage Deduction Laws
Wage Exemption Regulations
Worker and Community Right to Know Law
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TEXAS

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Child Labor Work Permits
Clean Air Regulations
Choking Training
Entertainment license/fee/tax
Family Leave Law
Fire Code Compliance
First Aid-trained employee - all shifts
Health license/fees/inspections
Hour restrictions for employees sub-16 years
Hour restrictions for employees 16 & 17
Liability Laws
Liquor License/fees
Mandatory rest breaks
Meals tax (on employee meals)
Minimum Wage law
Miscellaneous business licenses
Noise compliance
Occupational restrictions for minors
Payment of wage laws
Poster requirements
Property taxes
Record keeping requirements/wage reporting
Room occupancy limitations
Room occupancy tax
Sales tax (one of highest in nation)
Sanitation/food preparation regulations
Smoking ordinances
Tip Credit Law
Unemployment Insurance
Unemployment Tax
Universal Health Care
Wage Deduction Laws
Workers' Compensation Insurance
Zoning (comprehensive growth management restrictions)

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This page shows 15 changes the U.S. Congress has made just since 1985 in federal laws affecting restaurants. On the other side is a comprehensive list of all the federal and state rules covering restaurateurs.

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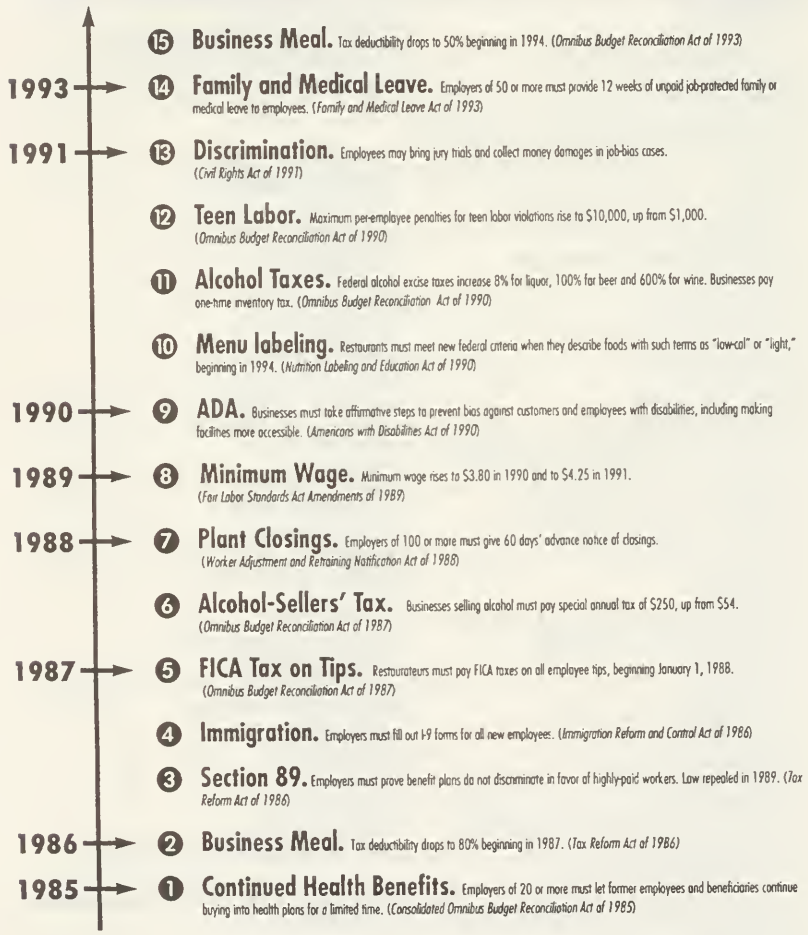
Just becoming familiar with the laws is a daunting task. But consider the costs of complying—in time and in money. And consider the liability if a business owner misses something.

It's no wonder restaurateurs are extremely worried about the proposals Congress is discussing, especially a health-benefits mandate.



National Restaurant Association • 1200 Seventeenth Street, NW • Washington, DC 20036 • (202) 331-5900

Chairman WILLIAMS. We apologize for having to interrupt twice. It is unusual for any member who happens to be chairing to do that, but because we are under such time constraints, we do want to hear from the other witness.

Jeanette Prear is the President and CEO of Day-Med Health Maintenance Plan. We thank you for being with us.

Ms. PREAR. Yes, I am President and Chief Executive Officer of Day-Med Health Maintenance Plan. Our corporate office is in Dayton, Ohio.

We employ 100 employees and I am particularly pleased to be here to offer testimony today, because we insure many of the small companies that have been talked about today.

We insure employer group sizes of 2 employees to 3,000 employees. We cover restaurant owners, tool and die companies, utility companies, department stores and the like from small, medium and large companies.

It has been an experience over the past two years covering these employees, but what we found we had to do in order to reduce the costs that we have had in health care is to combine them in what we call a small group association. Combining them into small groups such as COSE allows them to share the opportunities of rates such as larger employers.

We find that the owners have been bombarded daily with the cost of office space, supplies, equipment, et cetera, and that is why we chose to go this route and combine them into a large entity.

I would like to share with you a few comments that I have relative to some interviews that I have done with some small businesses; one in particular.

We have a potential client we are working with. He owns a fast food establishment. The company employs 38 employees, 34 of which are part-time employees, work usually 30 hours or less a week. All the employees start at the minimum wage.

The owner describes his standard employee profile as marginal, minimum wage type. He talks about how some of their attitudes are here today, gone tomorrow. He exhibits a grave frustration in having to continuously train and retrain the employees.

Many of the employees are teenage single parents, high school dropouts and those without a real sense of what it means to be an honest, committed reliable employee. He told how he uses health insurance as a benefit reserved for management. This is because the part-time employees don't have a real interest in health insurance and especially are not willing to pay for the health insurance. So it is reserved for managers.

He indicated that he doesn't have the gross revenues to provide the health insurance at no cost to the employee nor does he have the gross revenues to provide the insurance at no cost to the managers; so they share in the costs. The insurance proposals that he had received had costs ranging from $110 on a single contract per month to $302 on a family contract; and that was for an 80/20 program. The proposals that he received from an HMO had a cost of $98 a month on a single contract to $200 on a family contract. The HMO covered all the provider and pharmaceutical services, excluded dental. If he would select the HMO program, the employer would incorporate a cost of about $4,100 a month for the insurance.

He claims that if he does this, he would have to reduce his staff. He would have to possibly close one of his chains because at this point he is struggling and cannot afford the additional expense.

The small business owner and others are concerned about the cost. Quite simply, how can they afford to pay the toll for health care coverage and still survive?

The businesses realize, and we recognize the fact, that we must do something about health care reform. We must encourage the employers to participate in some form of group insurance.

But how do we do that? How do we do that with not as much cost to the employer? And we are suggesting at this time in looking at the proposal as it is written, that this committee should consider modification of the proposal, modifying it to increase the subsidy that is going to be provided to the small businesses in order to make the coverage affordable for the smaller employer.

I thank you for the opportunity to speak. And I would be happy to welcome and entertain any questions.

I wear two hats: one, I am the insurer, and I am also a smaller employer.

[The prepared statement of Ms. Prear follows:]

Jeanette C. Prear, President/CEO

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To the Chairman and Congressional Committee Members on Education and Labor and Subcommittee on Labor-Management Relations:

It is my pleasure to appear at this hearing on health care reform and to have the opportunity to offer my thoughts and perceptions regarding the effect of the proposed Health Security Act's effect on businesses. As the President/CEO I represent DayMed Health Maintenance Plan, an HMO in Dayton, Ohio. DayMed is an employer of 100 employees. I am particularly pleased to offer testimony because many of the organizations we insure are small businesses.

There are clearly several major issues confronting health care reform, but the economic impact is one that worries the business community the most. Following are some observations for your consideration in addressing the effect the Act will have on businesses in America, especially small businesses.

RESPECTFULLY SUBMITTED:

Jeanette C. Prear
President/CEO

JCP/mlp

encl.

As a health maintenance organization (HMO) that serves business, our network is made up of employer groups ranging in size from two (2) employees to approximately 3000 employees. These businesses represent many industries and professional organizations, such as tool and die manufacturers, fast food chains, restaurants, municipalities, retail sales organizations, utility companies, attorneys and doctors. From these associations we have come to gain substantial insight into what it means to run a business.

To run a small business today means its owners recognize a need for independence, personal commitment and responsibility. Today's small business owner realizes that putting in long, exhausting hours and spending your life's savings to pursue that independence is just par for the course. They know that to get ahead of the game, they have to have a keen sense of who they are and where they want to go. They also must have the ability to control cost and the insight to make sound business decisions. I don't have to tell this Committee that the costs associated with a small business can be staggering. Owners are bombarded daily with costs for everything from office and factory space to equipment and materials, letterhead, envelopes and paper clips.

I would like the Committee to bear in mind that as an HMO, our business is to provide comprehensive health care services to the employees of our clients. We provide those services in an efficient and cost-efficient manner. We would be remiss in our charge to this Committee if we didn't reflect the confusion, fear and worry many small businesses are facing at the possibility of health care reform in America as it is being proposed presently

After having read President Clinton's Health Care Security Act recently submitted to Congress, I come to this hearing with mixed feelings. On one hand I add my voice to the rising chorus of Americans from all across this country and from every segment of our society calling for desperately needed reform in the health care industry I have seen first hand the inequitities of the system that serves some and ignores others. However, I as a member of the health care insuring community that is painted as the villain and the primary and principle cause of an industry out of control. I speak with great concern.

The cost of health care is declared to have risen far more sharply than any other segment of our economy and has been at the center of concern of most of our fellow citizens. It is said that the health care industry absorbs a disproportionate share of our income. In short, it is understood by many of our fellow citizens that one simply cannot afford to get sick or to get old. This narrow view of the cause and effect in health care and what drives the escalating cost does great disservice to the remedy we seek to make and the changes required to affect the cure. The rationale that places the preponderance of the problem at the feet of the health care insuring community is fundamentally flawed and certainly is a hindrance to the healing that surely must come if Health Care Reform is to become a reality.

If the diagnosis for Health Care Reform is to be complete then several issues must be adequately addressed. Among those issues is a fundamental understanding of who the insurers are. In many cases, the "insurer" are not large national associations paying $6 million to combat the President's current proposal.

They are other small employees such as my company spending countless hours with providers and members, including medicaid members to achieve a balance in cost -- cost to DayMed to provide the coverage, and cost to the employer to buy our coverage.

Please allow me to share with this Committee some concerns small business people are having.

A potential client we are working with owns a fast food establishment. The company employs thirty-eight (38) employees, thirty-four (34) of which are part-time employees, working usually less than thirty (30) hours per week. All the employees start at a minimum wage. The owner describes his standard employee profile as the "marginal, minimum wage type." He talks about how they have "here-today and gone-tomorrow" syndrome.

He exhibits a grave frustration in having to continually train and retrain employees. Many of his employees are teenage single parents, high school drop-outs and those with no real sense of what it means to be an honest, committed, and reliable employee. He tells us how he and others like him use health insurance as a benefit reserved for management. The benefit is reserved for managers because the other employees have no interest in and are not willing to share in the expense of, having a health insurance program for themselves. The business owner does not have the gross revenue needed to provide the insurance at no cost to the employee. Nor does he have the gross revenue to provide the management with the benefit at no cost to the manager. The insurance proposals he received had costs ranging from $110.00 per month on a single to $302.00 on the family contract. This proposal represented an 80/20 program. The proposals received from the HMO carried a cost of $98.00 per month on a single to $200.00 on the family contract. The HMO covered all provider and pharmaceutical services, excluding dental. If the employer would select the HMO program his monthly expense would be approximately $4,132. He claims his only option is to reduce his staff, reduce the hours he is open and close one of the chains. He also claims that if he would receive a government subsidy of at least a third, the staff reduction would still take place. He states that increased wages would definitely put him out of business.

The worst part of this very real scenario is that this person is a very caring individual. The business owner often helps his employees with cash advances and assistance with obtaining higher paying jobs. In every large city, there are smaller communities within which have employers such as this.

This small business owner and others are concerned with costs. Quite simply, how can they afford to pay the toll for health care coverage and still survive. They are small, growing, thriving, and some are just barely surviving.

The Health Security Act is an admirable undertaking. Its comprehensiveness is impressive We believe the Clinton Administration when they cite example after example of instances where our current system has allowed chronically ill children or incapacitated senior citizens to fall through the cracks.

Indeed, I, and those in my profession, try every day to plug those holes in the current system. We applaud the superlative motive of comprehensive health care for every American.

The smaller of the small businesses in this country recognize the effort as a formidable one. How can they not. But, they, as well as I, realize that many of them can simply not afford to pay even twenty (20) percent of premiums for their part-time employees.

Even if the premiums are shared, those premiums will be felt severely. Will it be a fair trade-off? Will it amount to an equitable resolution? Or, will it force the elimination of many of our small businesses who had the hope and the dreams and even the potential for success.

As I have tried to depict over the past several moments, the smaller small businesses we serve, be they African American-owned, female-owned or of any other designation, feel without a doubt, that they have the right to exist. The essence of this great country supports the belief that if you have what it takes to pursue your dream of a business of your own, you should be able to do so. This is not to say that we should not seek ideal situations. What we are saying, however, is that the many nice-to-haves in our world today should not be achieved by sacrificing any group or segment to achieve that ideal. In this vein, the Committee should consider modifications to the proposal, including increasing the subsidy to small businesses, to make coverage more affordable to the smaller employer.

As President and Chief Executive Officer of DAYMED HMP, Inc., Ohio's first and largest minority-owned health maintenance organization. I again thank you for the opportunity to speak today regarding small business and the Health Security Act. I can think of few topics that are of more importance and interest to me.

Those of us who are committed to the delivery of the highest quality of care to all our enrollees, relish the opportunity to offer service to the citizens of our United States. We seek to serve without discrimination, not only in regard to race, color or health status, but also without discrimination to business size and net worth.

The current administration has given us a prescription for change to provide health security to each and every American citizen. Let us take every precaution to ensure the appropriate dosage is adequately tested to guard against any adverse side effects on business, especially small business in America.

Chairman WILLIAMS. Well, thank you very much. And I thank all of you.

I want to say, as Chair of this committee and as a former small business person, I used to be in the restaurant business, that I have a real understanding of the burdens that regulation creates. I also understand the burden that layers of bureaucracy can place on businesses, both large and small.

I do note, however, that a clear look at congressional history demonstrates conclusively that in almost every instance that the Congress of the United States has acted to pass important laws, Congress has exhibited great patience. Congress has been patient for five decades with regard to health care. Congress was patient for many decades with regard to minimum wage legislation. This list goes on. For example, Congress patienty waited 100 years before ending clean water legislation.

The Congress tries to be patient with these important issues. Congress does not just attempt to slam dunk new laws without needs.

With regard to the cost of postage, I saw an interesting thing the other day—the price for postage has not gone down, nor have the prices I pay small business and big business for their products gone down. But postage price has not followed inflation. Today the price of a first class stamp would be more than $5 if postage had followed the inflation rate.

Not all government-run agencies deserve the kind of criticism that they sometimes receive. I say this as a person who has been on both sides of the street. I criticize government when it is appropriate. Other times government-run agencies deserve no criticism.

I think as Americans we have to kind of hitch up and say all the news is not bad. Everything is not being run terribly either by business or government.

Mrs. Roukema, questions for these panelists. I have 12 questions but I don't have the time.

Mrs. ROUKEMA. We don't have time for all of them.

You have given good testimony here, and there is a wide divergence between similar business groups and your impressions.

Ms. Prear pointed out that there may be a need for increased subsidy, that is if you assume all the other questions about alliances are acceptable, which I don't necessarily say they are acceptable to me. That is still an open question.

But, of course, the increased subsidy is a route. My question to the employers here who are opposed to the program is if we don't use this route, that is connecting directly to the job market, who does pay then for the coverage?

I understand Mrs. Fugo's problem, but the question she hasn't answered is who then does pay if we don't put it on your back?

Mrs. FUGO. Is that a question—first of all, I am 40 years old this year and in 1953 my parents had no health care and coverage. The reality is the idea that employers cover everybody is less in age than I am. I know people today, people that, you know, that are in their 60s that still do buy health insurance over and above medicare.

So, yes, business should try to provide as much as possible, but the idea is how do you make health care insurance as available to

people as possible? Whether they buy it through their job or they buy it directly, I don't see why it is mutually exclusive.

Mrs. ROUKEMA. As a Republican, I am more than sympathetic to your problem. Much more so. I want to preserve the small business profitability, and your ability to stay in business.

Unfortunately, what you are outlining there is simply out of the realm of possibility for the low-income worker. There is no pool that would provide that low-income worker more insurance coverage.

And in early 1950s, that was a possibility. But it isn't under the present rules. I want to leave—and we have to go for a vote—I want to leave you with this thought.

There is the other side to it, and I think Mr. Connor made an excellent presentation, but the other side to Mr. Mehringer, who is very happy with the situation, I don't know why any relatively small business person would want to pick up the direct costs for the social costs that are adding so exponentially to the health insurance coverage, whether it be drugs or AIDS or crime or the costs of new technologies or premature babies. These costs are growing out of sight, and I really don't think the small business community should necessarily have to be directly paying for them, but that doesn't answer the question. It only poses yet another series of questions, but I thank you very much for your testimony.

Chairman WILLIAMS. I see our other two members have left to vote. That means that I have a couple of minutes. Let me see if I can get a couple of questions in here.

The latest statistics the committee has been able to develop tells us that about 29 percent, or only 29 percent of all employees—that work for companies with fewer than 500 employees—have really no choice in their health care plans. Being that Americans want choice, if you ask these employees what they want they say, "we want choice."

But 29 percent of people who work for large to small employers do not have choice now. Why wouldn't the President's plan be better for these people?

Mrs. FUGO. We are through the COSE program, but we have five plans to choose from and we leave it to up our employees. They pick now.

Chairman WILLIAMS. Should all employees be offered that type of choice?

Mrs. FUGO. If the choice is out there, it is up to the employers to go out and find the programs that are in the marketplace.

Chairman WILLIAMS. And 70 percent of them have not done that. The point is we have waited for decades, how long is it going to take?

Mr. MEHRINGER. I have a lot of choice theoretically in the market, but last February when I went out to exercise that choice, I was turned down. One group turned us down because two of my employees are sisters. That is how absurd the system is. We have no choice. The choice that people talk about is very theoretical in a lot of cases.

Ms. PREAR. But, Mr. Chairman, the President's plan, as outlined, identifies choice in health plans that an employee can select. It does not identify the providers associated with that health plan.

So still choice is limited. You may be able to choose the health plan, but you may not be able to choose the provider that you want. And the providers must contract with the health plans and that is up to the provider and he bases that decision on cost.

Mr. MOEHRLE. For my employees, flatly the Clinton plan offers considerably more choice. Right now they have no choice. The only person that makes a decision about their health care is me. And this system, at least, would change that. I have no business making a decision about what kind of health care my employees get, but that is the way the system is structured now.

Chairman WILLIAMS. One other question I want to pose to you considers the matter of how in this country we are going to cover, particularly if we use something similar to the Clinton system, temporary or part-time employees? And if we do not cover them, if we do not mandate their coverage, then will employers, would all of you, begin to replace full-time employees, particularly future full-time employees, with part-time employees, so that employers can get out from under, maybe understandably, the costs for providing health care coverage? If we believe in universal coverage, how do we resolve that?

Mr. MOEHRLE. There would be that incentive. No question.

Mr. MEHRINGER. I understand that companies that operate in Germany, American companies that operate in Germany, do that very thing. They employ a lot of part-time employees to avoid the socialized medicine system.

Mrs. FUGO. I employ a lot of part-time people. I do not find that part-time people come to me for benefits. They are looking for additional income and are willing to work more than a 40-hour standard week and are willing to work hard. The reality is that general mandates, in general, are putting pressure on—to be honest about it, as a small business person today you think two and three times before you hire anybody because of the cost of employing any person, whether it is full-time or part-time. And honestly, the joke is the administrative support of a part-time employee is more than a full-time employee.

Chairman WILLIAMS. Under the Clinton plan it is pro rata.

Mrs. FUGO. But it is checking 200 people and 200 spousal relationships and 200 people with dependents, so the administrative burden of having those people around is greater than having a person that you know and you work with each week. A part-time person is more expensive administratively just because you don't see that person every day. You have to track that person down. There is more coordination in running a part-time staff.

Chairman WILLIAMS. If you had a part-time employee, you would not have to check to see if they are covered elsewhere; you simply would have to pay a pro rata share of their insurance premium, depending on how many hours they work for you, period.

Mrs. FUGO. The emphasis would be to keep everybody working less than 10 hours, from the way I understand the system to work, to keep it as simple as possible administratively.

Chairman WILLIAMS. Again, thanks to each of you for coming in.

Let me make a final point, this point has to do with kind of a bunker mentality here in Congress, and maybe it has to do with the special interest groups attacking the wall. For some reason,

major issues such as health care, where really everybody is basically on the same side in this country, or at least most people are, over the past 10 or 15 years people have begun to take on antagonistic relationships with respect to these basic issues. Some Americans line up on one side thinking that the other side is trying to put them out of work. While those people on the other side think that there are a lot of freeloaders out there trying to evade their responsibilities. Neither are true.

In preparing the Clinton plan, the task force worked with small business folks and people from throughout the country. The Congress wants to work with all of the people. We take your testimony very seriously.

I do not find for the most part a feeling of antagonism in this room today. But I do want to leave you with the thought that we are all trying to achieve the same thing here. With regard to business, we all want to get the costs of health care down, get more people covered and stop the cost shifting. We want to accomplish these goals so that the Ford Motor Company is no longer spending more for health care than they are spending on steel for their automobiles.

We are all on the same side in trying to encourage better business and social climate in the country and your testimony has been helpful, I hope, toward getting us toward that.

Thank you very much.

The hearing is adjourned.

[Whereupon, at 12:15 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

I. Introduction

Mr. Chairman, members of the Subcommittee, I am William Connor, Director of Benefits of The Mead Corporation. On behalf of the Association of Private Pension and Welfare Plans (APPWP), I am pleased to offer comments on the President's health reform proposal.

APPWP, like The Mead Corporation, firmly believes that health reform legislation should build on rather than dismantle employment-based health benefits. The current employment-based system is not perfect. It would be improved by well-designed reform legislation. However, the employment-based system provides the strongest foundation for achieving universal coverage, cost containment and quality improvement. Eliminating rather than strengthening employers' role as active purchasers of health benefits would lead to a less affordable and lower quality health care system for an increasing number of Americans.

For practical purposes, we believe the Clinton Administration's Health Security Act would eliminate employment-based health benefits. While employers would have an increased responsibility to pay for workers' health benefits, their ability to control costs and improve quality would be eliminated. As a result, we have serious reservations about the Administration plan as it is currently drafted. We reach this conclusion despite the many positive aspects of the President's plan.

APPWP's reservations about the current version of the Health Security Act should not be mistaken as opposition to health reform. In December 1992 APPWP adopted a comprehensive health reform plan which would achieve universal coverage, hold down costs and improve quality through a reformed employment-based system. Critically, we define an employment-based system as one in which employers are active purchasers of health benefits, rather than simply passive payers of assessments set by the government.

Instead of focusing on APPWP's proposal this morning, I will explain a few of our key concerns about the Clinton plan. These include (1) the elimination of employers as purchasers of health benefits, (2) state flexibility, and (3) creation of barriers to market competition and effective managed care plans.

I would like to reiterate the context for APPWP's concerns. President Clinton's leadership has irreversibly set the country down the road toward passage of a comprehensive health reform bill. Many elements of the President's plan should be included in the bill that passes. However, the President's proposal as currently drafted should not be passed without major changes.

Before addressing our specific concerns, I will take a moment to explain what the Mead Corporation has done with its health benefits program. We are taking an innovative approach to managed care under which our employees are not restricted to a closed list of

providers. Rather, employees may choose any primary care physician they want to manage their care. As long as that care, including visits to specialists, hospitalization, etc., is coordinated by the primary care physician, full benefits are provided. We believe that the primary care physician's normal prudent approach to practicing medicine will result in better care for our employees at lower cost.

The Mead Corporation also operates (1) special programs to manage mental health, chemical dependency, and prescription drugs and (2) some traditional forms of managed care with restricted provider panels.

II. Elimination of Employers as Health Benefit Purchasers

We believe the Health Security Act would eliminate virtually all employers from their current role in purchasing health benefits offered to their employees. Employers' purchasing role would be taken over by "regional alliances" which would be operated, directly or indirectly, by state governments. Eliminating employers from their role in purchasing health benefits is the Health Security Act's fundamental flaw, and is likely to result in increased costs, increased selection effects in the insurance market, and lower quality health care.

The Administration cites examples of employer-sponsored health benefit plans that have achieved positive results in arguing that its proposal for regional alliances "builds on proven models." The Administration is correct to point out that employer-sponsored plans have achieved positive results, but these results are not attributable to arrangements that are similar to regional alliances. The employer-sponsored plans which the Administration identifies as proven models work well because employers are involved as active purchasers of health benefits.

A. Mechanisms Used to Eliminate Employers' Role

The Administration's plan uses several mechanisms to eliminate employers as purchasers of health benefits. First, all private employers with fewer than 5000 full-time employees and all public employers (regardless of size) would be required to purchase health benefits through a regional alliance. These employers, accounting for the vast majority of the workforce, would play no direct role in purchasing health benefits.

Private firms with more than 5,000 full-time workers would face overwhelming disincentives if they attempted to form a corporate alliance. A partial list of these disincentives includes the following items:

- **Size and Power of Regional Alliances.** Employers outside of regional alliances would represent, at most, a few percent of the

market. This would deprive them of the bargaining leverage needed to negotiate cost-saving and quality-enhancing initiatives that require health plans to change the way they do business. Additionally, large employers would be exposed to cost-shifting by regional alliances and Medicare.

• **Discriminatory Taxes on Employers Forming Corporate Alliances.** Employers forming regional alliances would be required to pay a 1% payroll tax. This tax discriminates against corporate alliances. Even if some of the costs this tax is intended to cover are built into regional alliance premiums, regional alliance premiums are capped as a percentage of payroll while corporate alliance premiums are not. Additionally, when costs are built into premiums a portion is paid directly by workers. The entire payroll tax is paid directly by employers. At Mead, this would result in an immediate increase over our current health care costs of more than 9%.

APPWP supports broad-based financing to cover the cost of needed and efficiently operated public programs. To date, the case has not been made that a 1% payroll tax on corporate alliances meets these criteria.

• **Rules Reducing Employers' Ability to Manage Costs.** Large employers' limited purchasing power would be further diluted by the requirement that they offer at least three health plans. Moreover, large employers would be constrained from selecting three highly efficient plans by the requirement that they offer at least one fee-for-service or point-of-service plan. These limits on cost management would discourage large employers from choosing the corporate alliance option.

• **Unavailability of Public Subsidies to Corporate Alliances.** Employers forming corporate alliances, unlike those joining regional alliances, would not be eligible for government subsidies to cap their health expenditures as a percent of payroll. Additionally, employers forming corporate alliances would be responsible for providing low wage workers with enhanced premium subsidies. Government subsidies would cover this cost for employers joining regional alliances.

B. Consequences of Eliminating Employers from Health Benefits Purchasing

1. Increased Costs. Employers are driving the ongoing revolution in the organization of health care delivery systems and the health care market. There is increasing evidence that these employer-led efforts are beginning to payoff. For instance, a recent study of employer-sponsored health plans by KPMG Peat Marwick indicates that health cost increases, while still too high, are slowing. Employers are limiting cost increases even though Medicaid and Medicare cost-shifting adds several percentage points to the annual

increase in employers' health benefit costs.

Under the Health Security Act employers would have neither the incentive nor the means to influence health costs, since they would be limited to paying bills wholly determined by others. As a result, the employer-generated cost containment pressure which is beginning to achieve some success would be eliminated.

Multiple purchasers are required to successfully control costs. By eliminating employers as purchasers, the Health Security Act also eliminates this essential source of innovation. Different employers have emphasized different approaches, e.g., collective purchasing, negotiating quality standards with health plans, restructuring premium subsidies to employees, new data technologies, and requiring health plans to move toward integrated delivery systems. As mentioned previously, Mead has adopted a highly innovative approach to purchasing care through primary care physicians.

A state-run regional alliance is no substitute for multiple employers actively purchasing health benefits. No single entity could replicate the range of cost control and quality improvement initiatives undertaken by multiple active purchasers. Additionally, a government entity is less likely than private purchasers to make the tough choices needed to cut costs and improve quality, since doing so could generate intense political opposition. For instance, the Health Security Act would require fee-for-service offerings, even though many employers are moving away from such options as an inefficient method of purchasing health care.

2. Selection Effects. The Health Security Act would shift over 130 million Americans from group choice of health plan (entire group enrolls in one plan, or the group offers a limited selection of plans from which its members choose) to individual choice among all plans offered through a regional alliance. This could have the unintended consequence of increasing risk selection among health plans, while hampering efforts to achieve risk adjustment among plans.

3. Lower Quality Care. Many employers seeking to contain costs have focused on improving quality. For instance, the Minnesota Business Health Care Action Group (a collective purchasing initiative by 21 employers covering over 200,000 lives), the Digital Equipment Corporation, and the Cincinnati Payer Initiative (General Electric, Procter and Gamble, Kroger and Cincinnati Bell) are aggressively implementing leading-edge quality improvement strategies.

Government administrators are likely to focus almost exclusively on meeting their budget through reimbursement rules, to the detriment of quality improvement. This clearly has been the case in

Medicare, where quality is a much lower priority than administering price control schemes.

III. State Flexibility

Nationally uniform rules establishing a competitive health care market are essential to the private sector's ability to cut costs and improve quality. National uniformity is critical to cooperative labor-management relations in multistate firms and to multistate employers' ability to efficiently administer health benefits. We also support national uniformity in light of our disappointing experience with laws in many states that have been hostile to the private sector's cost control initiatives. Finally, millions of Americans cross state borders to obtain jobs and/or health care. State-by-state health system rules could create daunting problems in the nation's many interstate health care and labor markets.

Allowing states to vary health system rules governing the large percentage of the market made up of smaller employers creates nearly as many problems as allowing states to regulate large, multistate employer plans. Rules governing the majority of the market will define the range of possibilities available to multistate employers.

Several elements of the Administration's plan appropriately recognize the need for national uniformity. For instance, one provision designates the Secretary of Labor rather than the states as responsible for enforcing corporate alliance standards. Additionally, the Health Security Act does not authorize state waivers from federal standards on a provision-by-provision basis. These provisions make good sense.

Unfortunately, the Health Security Act also includes provisions which would destroy national uniformity. These provisions include the following items:

• **Single Payer Option for All or Part of a State.** States could require all employers to participate in a single payer system. The single payer system could cover all or part of a state. This could lead to inconsistent treatment of workers in different states, greatly complicating bargaining and pressuring employers to make available to all employees the most permissive arrangements available to any of their employees.

Additionally, it is not clear how employers responsible for organizing network-based coverage in one state could provide coverage and control costs for workers who receive care in an adjoining state if the adjoining state elects the single payer option. Similarly, provider networks in a non-single payer state could be forced to operate under different rules and incentives when serving patients covered by a single payer state. This will

drive up costs and increase administrative complexity for all payers. All of these problems are magnified if portions of states become single payer areas.

The state single payer option creates an additional problem for multistate employers. Employees residing in single payer states (or areas) would not count for purposes of determining whether an employer is large enough to form a corporate alliance. An employer doing an excellent job of managing benefits could be forced into a regional alliance if a single state chooses the single payer option.

• **State Administration of New ERISA Title.** The Health Security Act would create a state role in adjudicating participants' claims against corporate alliances. We have grave concerns about the expansion of remedies for claims denial. These concerns are compounded by the numerous differing standards governing claims denial likely to arise out of state adjudication. While appeal is available to a federal agency and the federal courts, cost and other practical factors prevent appeals from resolving problems related to state-by-state claims adjudication.

• **State-Determined Fee Schedules.** The Health Security Act mandates that each fee-for-service plan (and fee-for-service portion of network plans), including plans which corporate alliances would be required to offer, pay providers according to a fee schedule established by regional alliances. The incentives driving regional alliances in setting fee schedules could lead to more generous reimbursement than a corporate alliance would find to be justified.

• **Mandating Additional Benefits.** States are permitted to add benefits to the national package, so long as they do not rely on funds provided under the Health Security Act. Workers in one state are likely to seek the benefits received by their co-workers in other states, particularly if their employer is taxed to pay for the additional benefits.

• **Mandated Contracting with Essential Community Providers.** States can require corporate alliance health plans (as well as regional alliance health plans) to contract with providers in underserved areas designated as "essential community providers" by the federal government. Government has a legitimate interest in assuring that health plans offer enrollees appropriate geographic access. However, this particular approach could insulate providers from market pressure to improve cost and quality performance, and deny corporate alliances the opportunity to manage costs as effectively as possible. Health plans should be accountable for providing appropriate access to care, not care from state-specified providers.

Allowing states to require health plans to contract with specified providers also raises serious conflict of interest problems. Many

essential community providers may be state-sponsored institutions.

IV. Barriers to Competition and Effective Managed Care Plans

The Health Security Act attempts to create a framework that will stimulate price and quality competition among health plans and the development of increasingly effective managed care plans. APPWP agrees with this framework and with several of the policies adopted to promote competition and effective managed care (e.g, preemption of anti-managed care and anti-managed pharmaceutical laws, expanded role for mid-level practitioners). Nonetheless, we are concerned that several of the Act's provisions are inconsistent with the framework. A partial list of items which could tend to reduce competition and the effectiveness of managed care plans follows:

• **Eliminating Group Choice of Health Plans.** Competition is fostered by multiple group purchasers (i.e., employers) negotiating and selectively contracting with health plans. As already discussed, group purchasing would be eliminated by the Health Security Act.

Since group purchasers would be eliminated, competition is restricted to encouraging individuals to select lower cost health plans from the large number of plans most regional alliances would offer. Giving individuals appropriate incentives to select efficient health plans will promote cost containment, and should be a key approach included in health reform legislation. However, it may be unrealistic to expect individual choice among a large number of health plans, including high cost plans, to carry the full burden of cost containment.

"Structured choice," in which a group purchaser offers a limited number of plans (which might not include high cost options) from which consumers with appropriate incentives choose their coverage, may be more likely to control costs. Notably, many employers with a record of successful cost control--including employers whose experience the Administration cites as demonstrating the value of the regional alliance concept--have moved away from unstructured choice among a large number of health plans to structured choice among a limited number of plans.

• **Weakness of Incentives for Individuals to Choose Efficient Health Plans.** The concept of giving individuals a financial incentive to choose an efficient health plan is sound. However, the Health Security Act's specific rules governing the premium subsidy individuals receive may not create a strong enough incentive to achieve the desired level of cost control.

First, the minimum subsidy all individuals receive--80% of the average weighted premium in an alliance--is generous. Depending on various factors which determine the subsidy's dollar value within each alliance, an individual's share of premiums for even an

expensive plan might be relatively small. Note that the Health Security Act's minimum premium subsidy may exceed the premium subsidy many workers now receive. Workers receiving an increased premium subsidy as a result of the Health Security Act are unlikely to be strongly motivated to switch their coverage to more efficient plans.

Second, under the Health Security Act, employer premium subsidies above the required minimum continue to be excluded from employee income for tax purposes. This gives employees an incentive to seek an additional employer premium subsidy. This incentive would be reinforced in firms which realize savings by moving into community-rated coverage and receiving other subsidies. Their workers may expect to obtain a share of these savings through employer payment of workers' share of premiums.

Employers who pay for workers' share of premiums must make the same contribution for all employees, and provide a cash rebate to an employee if the contribution exceeds the total premium of the health plan the employee selects. The rebate would be taxable income to the employee. Overall, this structure encourages employees to seek a high premium subsidy as part of their overall compensation, since employees using it to pay premiums would receive tax advantages while those electing a rebate would not be in a different position than at present.

• **Premium Caps.** The Administration's premium cap proposal raises numerous critically important issues requiring careful analysis. Here, I raise only two of these issues which bear on whether the Health Security Act would create market competition that will control costs.

First, a health plan with a rate of increase above the regional alliance-wide permitted rate of increase in a given year could be penalized, even if it is a low cost plan. More expensive plans which hold down their rate of increase would not be penalized. This creates an incentive for a health plan to raise premiums by the maximum permissible amount each year even if it could make do with less, in order to create a cushion in the event that it must reduce its rate of increase in future years to avoid a financial penalty. Similarly, health plans would have an incentive to set a higher base cost than they otherwise might in the first year, in order to build a cushion against future penalties triggered by other plans' high costs driving down every plan's permitted rate of increase.

Second, regional alliances actively negotiate premiums with each health plan they offer. Whether each plan stays within budget is dependent on the premiums charged by every other plan. As a result, a regional alliance's bargaining strategy and skill could create advantages and disadvantages for particular plans unrelated to the plans' ability to control costs and improve quality. For

instance, if a regional alliance faced political pressure to keep an inefficient plan alive, it could do so by forcing more efficient plans to reduce their premiums.

• **Rigid Cost-Sharing Rules.** The Health Security Act includes three options for cost-sharing, with permissible cost-sharing under each option defined in detail. Reasonable cost-sharing limits are an appropriate consumer protection. However, freezing cost-sharing in place through detailed specification of cost-sharing will hamper the innovate use of cost-sharing to achieve cost containment. For instance, network-based plans which currently use nominal cost-sharing may wish to experiment with intermediate levels of cost-sharing, but would be confined to either nominal or high levels. Similarly, employers and health plans might wish to experiment with income-related cost-sharing in order to give highly compensated workers the same financial incentives as lower compensated workers, but would not be permitted to do so.

Additionally, the Health Security Act's cost-sharing rules for use of non-network providers may create too small an economic incentive to encourage use of network providers.

• **Mandated Use of Specific Providers.** The Health Security Act grants preferred status to specified providers, including "essential community providers" and academic health centers. Health plans would be required to do business with these providers, regardless of their efficiency or quality. This will reduce pressure on providers to improve their operations, and make it more difficult for health plans to effectively manage their networks' cost and quality.

V. Conclusion

Mr. Chairman, members of the Subcommittee, we are confident that legislation can be crafted which would meet or exceed every goal President Clinton has set for health reform and produce a better employment-based system than we have today. APPWP has already developed detailed proposals which would achieve an improved health care system through employment-based, market-driven policies. APPWP and The Mead Corporation would be pleased to work with the Subcommittee to develop further detailed proposals that will address your concerns and ours.

Mr. Chairman, members of the Subcommittee, I would be pleased to answer any questions you may have.

NATIONAL EDUCATION ASSOCIATION

The 2.1 million member National Education Association, which represents education employees in the nation's public elementary, secondary, vocational, and postsecondary schools, appreciates the opportunity to share our views on an issue of vital importance to the nation's children and to all Americans: health care reform.

The people have spoken. The time for health care reform has come. And the NEA pledges to work with this Administration, this Congress, and all other Americans who will support a plan that is comprehensive, responsible, and compassionate.

In September 1986, NEA testified before the Select Committee on Aging on the United States Health Act, offered by Rep. Edward Roybal of California. This legislation -- which would have expanded access, assured quality, and controlled costs -- was introduced, one hearing was held, and no other substantive action was taken. In the view of most Members of Congress, national health care reform was simply not a priority.

What a different world we live in today. Rather than saying we can't afford health care reform, the consensus among most Americans is that we can't afford not to institute comprehensive changes in our health care system.

NEA commends President Clinton for bringing health care reform to the nation's agenda and for undertaking the formidable task of developing a proposal that addresses the many problems that exist in delivery, access, and cost. The Administration's proposal must be the starting point for health care reform. We are heartened by Congress' willingness to take this issue on, and we pledge to work with you to preserve and strengthen the essential elements of the President's plan. Attached to our testimony is a copy of a statement of principles on health care reform, adopted by some 8,000 delegates to our Representative Assembly in June 1993.

NEA believes that access to affordable comprehensive health care is a right of every citizen. Our goal is a single-payer health care plan for all residents of the United States, its territories, and the Commonwealth of Puerto Rico. We will support health care reform measures that move the U.S. closer to this goal and that achieve universal access to comprehensive health care coverage, control costs while assuring quality, emphasize prevention of health care problems, and are financed by means that assure greater equity in the funding of that health care.

The Clinton Administration's proposal for a universal guarantee of a comprehensive benefits package is an important step toward real and lasting improvement in our health care system. In particular, we support the comprehensive benefits package with its emphasis on preventive care, the options for coverage, the guarantee of coverage and continuity, and cost controls. Universality means more than access in theory; Congress must provide the resources to make access to quality health care services affordable to every American.

NEA members have a unique perspective on the issue of health care. As educators, we are concerned about the gaps in the present system and the impact those inadequacies have on public school students. As individuals committed to enhancing the quality of public education, we are concerned about the growing share of our nation's resources that health care costs consume, especially inasmuch as they detract from governments' ability to provide adequate resources for education. And as public employees, we have experienced the same challenges as other middle-income Americans in being able to afford adequate coverage for ourselves and our families.

Health Care, Children, and the Future

Of the 37 million Americans with no health care coverage, at least 10 million are children. Inadequate health care coverage is a serious obstacle to meeting the National Education Goals, particularly in the areas of readiness and student achievement. Too many children suffer from learning disabilities that are the result of inadequate prenatal care or from treatable medical conditions that go untreated because their families have little or no health care coverage.

Over the past decade, as health care premiums skyrocketed, many families have had to resort to health care coverage that provides assistance only for catastrophic conditions. Each day, our members work with children who suffer from a wide range of medical conditions that are treatable and/or preventable. Yet too many Americans now rely on hospital emergency wards as primary health care providers. As a result, they have no continuity of care or access to preventive treatments.

Health care costs and health insurance premiums rose sharply over the past decade, while average incomes fell. Employer-provided full family coverage is no longer a given. As unemployment rose, employers cut back on coverage and expanded cost-sharing. Individual coverage -- outside of a group plan -- became financially unattainable for most Americans.

The costs to families who lack health care coverage are great, but the costs to our society -- in both financial and human resources -- is monumental. A planned program of health care, including prenatal care, inoculations, well-baby care, and regular check-ups is not merely cost effective; it is an investment in our human resources and our nation's long-term economic and national security. The Clinton Administration's program takes these needs into account, and as such deserves the strong support of Congress.

We strongly support the provisions of the Administration's plan that would provide funding for school-based health clinics, comprehensive school health services, and training for school-based health personnel. Public schools can play an essential role in promoting health through education and screening, but schools must be provided the resources to perform those functions effectively.

Health Care and Education: Competition for Resources

NEA members are well aware of the impact of rising health care costs on governmental budgets. Over the past two decades, health care costs have absorbed a steadily growing share of resources at the state and local level. We strongly support

responsible measures to reduce health care costs, especially in areas of waste, over regulation, and fraud.

In 1960, spending for health care was approximately $27 billion, about one-fourth of the $103 billion spent for all education -- public and private, elementary, secondary, and postsecondary. By 1990, health care spending, at $666 billion, was nearly twice as much as education spending, at $365 billion.

State and local governments bear the responsibility for health care services in various ways. As employers, they shoulder the costs of coverage for more than 15 million employees. States share the costs of Medicaid with the federal government, and according the National Governors' Association, Medicaid costs have risen an average of 26 percent each year over the past three years. Many state, county, and municipal governments also provide direct health care services, including support for hospitals, clinics, outreach programs.

As the Members of this Subcommittee are well aware, Medicare and Medicaid costs have mushroomed in recent years. Total public expenditures for health care rose by 269 percent between 1980 and 1990. Medicare and Medicaid costs rose from almost 63 percent of public health care expenditures to more than 67 percent. By comparison, public expenditures for child and maternal health declined from 0.08 (eight one-hundredths) percent to 0.07 (seven one-hundredths) percent over the same period.

Unless health care costs are brought under control, health care expenditures are expected to consume the lion's share of public resources. The National Governors' Association projects that Medicaid costs alone will consume 22 percent of total state budgets by 1995. Between 1980 and 1992, Medicare costs rose from 5.4 percent of the total federal budget to 8 percent; other health care spending rose from 3.9 percent of the total federal budget to 6.4 percent.

To assure that costs for public employers do not grow out of control, it is critical that the 7.9 percent cap on payroll set for private employers also apply to public employers. At present, local school districts in seven to 10 states would exceed the 7.9 percent cap on health care premiums. The Administration's plan would phase in the cap on employer premiums; public employers should be treated equally in this regard from the first day of implementation.

NEA supports health care reform that will bring costs under control without diminishing quality or rationing services. Other industrialized nations -- most of which provide a much greater share of health care costs through public providers -- have proven it can be done. As the following chart illustrates, health care costs have risen much more slowly among our major economic competitors.

The Rise in Health Care Costs

	1980	1990	% of spending is public
U.S.	9.3%	12.4%	42%
Japan	6.4%	6.5%	71%
France	7.6%	8.9%	73%
Italy	6.9%	7.7%	71%
U.K.	5.8%	6.2%	85%
Germany	8.4%	8.1%	73%

The relative share and stability of health care costs among these nations would seem to argue for single-payer plans. Consequently, we believe that there should be no disincentive to states wishing to adopt a single-payer system. The Administration's most recent proposal eliminates barriers to states adopting a single-payer plan within the state, and these provisions must be included in any final legislation.

Health care reform, without meaningful cost controls, will only exacerbate the strains at the state and local level to address health care needs, education improvement and renewal, and other pressing demands.

Education Employees and Health Care Benefits

Like all Americans, NEA members are concerned about the nation's health care system from the standpoint of its impact on themselves and their families. A 1991 study by NEA compared the level of benefits provided public school teachers, other public employees, and persons employed in the private sector.

According to the U.S. Department of Labor, 37 percent of all teachers are required to contribute a portion of the premium for individual coverage, compared to 44 percent in the private sector. But teachers are much more likely to have to contribute for family coverage, by 73 to 64 percent, and their monthly contribution for family coverage is generally greater than among private employees.

Health care costs have grown considerably, as a share of average teachers' salaries, in recent years -- constraining the ability of school districts to provide the salary increases necessary to attract qualified teaching candidates. Between 1984 and 1989, health care costs rose from 7.7 percent of the average teacher's salary to 9.9 percent.

We are concerned that health care reform not worsen the economic pressures on school districts or education employees. Two circumstances of the public schools require some protection against an undue increase in the individual's share of health care premiums. Public employees include a number of part-time staff, both instructional and non-instructional, and public employees, including teachers, are -- as a rule -- not paid as well as other employees in jobs with comparable levels of responsibility or entrance requirements.

NEA strongly supports the cap on the percentage of wage income employees would have to pay for mandated premiums, and we believe it should not be set any higher than the proposed 3.9 percent.

For many years, NEA has steadfastly opposed the taxation of employee benefits. The Administration plan would exclude from taxation all elements of the guaranteed benefit package. And it would exclude, for 10 years, benefits beyond the basic plan that employees have at the time of adoption. These important provisions must be maintained. Employees have been able to gain these benefits over the years only by trading off wage increases, and they should not be disadvantaged by these changes. Moreover, Section 125 health care plans should be afforded similar protection during this 10-year period.

The Administration's plan proposes the imposition of the Medicare payroll tax on all public employees, a change we have opposed for a number of years. We remain deeply concerned that some state and local employees will be subject to this tax, and yet not be able to accrue sufficient quarters to qualify for Medicare by age 65. All public employees should be deemed qualified for Medicare coverage on reaching the age of 65, provided they have worked 40 quarters, regardless of whether or not such work was subject to the Social Security/Medicare tax.

Many of our members presently participate in health care organizations that are comparable to the regional alliances proposed in the Administration's health care plan. In order to minimize disruptions to beneficiaries and build on successful, existing structures, NEA believes that large public entities, such as trusts, voluntary employee benefit associations, and statewide plans, should be able to form separate alliances, if they are acting in the same manner as an alliance and enroll more than 50,000 members, including dependents.

Finally, given the historical link between collective bargaining and health care benefits, it is essential that the rights and benefits achieved through the collective bargaining process be protected in any health care initiative. We believe that the health care security of millions of families -- and ultimately of our nation -- has been made possible through the balance between employers and employees that is only possible in an environment of collective bargaining.

We recognize that this hearing is held early in a process that can be expected to take many months. The issue is complex, the stakes are high, and the interests of various affected individuals and institutions will often be in conflict. We pledge to assist this Committee and this Congress in understanding the impact health care reform will have on public schools, our members, and the children we serve. And we offer our strongest support to an Administration and a Congress committed to see this monumental task through.

Thank you.

National Education Association
Health Care Policy and Strategy Statement

Adopted by the NEA Board of Directors
February 12, 1993
Amended June 29, 1993

Preface: *The NEA supports the adoption of a single-payer health care plan for all residents of the United States, its territories, and the Commonwealth of Puerto Rico. The NEA will support health care reform measures that move the United States closer to this goal and which are consistent with the principles and policies set forth below.*

I. Universal Access

Every resident must be provided with a high level of comprehensive health care coverage.

The components of such coverage are preventive care, in and out-patient hospital care, in and out-patient surgery, doctor visits, chiropractic, diagnostic labs, radiology, prescription drugs, allergy care, organ transplants, mental health, substance abuse, hospice care, dental, vision, long term care, home health care, rehabilitative therapies, and necessary, durable medical equipment.

We oppose the imposition of cost sharing (co-pays), but if there must be some cost sharing, there must be no cost sharing for preventive services.

The coverage must include choice of physician.

Benefits not provided under the comprehensive national plan may be purchased or negotiated through collective bargaining, legislative action, or employer policies. Payment of the employee part of cost sharing may also be negotiated, legislated, or paid by the employer. Health care related benefits must not be taxed.

Health coverage for residents of the United Staes must not be limited to their employment, must be portable, and coverage must not be denied to anyone based on pre-existing conditions, their level of health, or income.

The national plan must prevent risk shifting such as termination or reduction of benefits by employers or providers.

II. Controls

Assured Quality along with meaningful Cost Control is the number one priority of NEA in its support of any national health reform.

The national health reform plan must include both professional and practitioner boards to establish and implement guidelines for medical practices and consumer boards to ensure consumer satisfaction and assess the outcome of medical services.

All medical services must be included in cost control measures.

Global Budgeting, with guidelines set by a broad based national board with the majority representing consumers, must be included in the reform package, and it must include all of the following:

- Specific, enforceable national expenditure limits
- Specific, enforceable state expenditure limits based on national expenditure guidelines
- Specific, enforceable institutional (hospital) expenditure limits
- Institution capital expenditure limits

Uniform Fee schedules must be established for all medical services. These schedules must include mechanisms to prevent abuses in the volume of procedures and prohibit balance billing and unbundling.

The reform package must include drug cost control measures.

Administrative efficiencies, including a single claims form and community rating, must be included in any reform.

The national plan should include malpractice reform in an effort to control costs which would establish appropriate medical protocols, provide methods to provide malpractice legal costs, and provide for fair compensation to malpractice victims.

Strong enforcement mechanisms must be built into all cost containment measures.

The NEA opposes Managed Competition and/or use of market competition as a vehicle for cost containment.

III. Financing (Long Term Goals and Immediate Steps)

NEA aims for a tax supported, single-payer health care plan in the United States. In the short term, however, NEA may support reforms that utilize taxes and/or employer payments to move us toward greater equity in funding.

Interim steps taken toward the ultimate goal must not cause a cost shift from employers to employees, or create "windfall" savings for employers. Employers must either be made to continue to shoulder their current share of the cost of health care, or they must share their "windfall" with employees or as a tax to pay for the general health care system.

Interim steps taken toward the ultimate goal must also not cause risk shifting by employers or health providers.

RESOLUTION H-6 : NATIONAL HEALTH CARE POLICY

The National Education Association believes that access to affordable comprehensive health care is a right of every resident.

The Association supports the adoption of a single-payer health care plan for all residents of the United States, its territories, and the Commonwealth of Puerto Rico.

The Association will support health care reform measures that move the United States closer to this goal and that achieve universal access to comprehensive health care problems, and are financed by means that assure greater equity in the funding of that health care.

The Association further believes that until a single-payer health care plan is adopted, Congress should make no cuts in Medicare/Medicaid benefit levels or in federal funding of the Medicare/Medicaid program.

NEW BUSINESS ITEM 1993-C

The NEA supports the adoption of a single-payer health care plan for all residents of the United States, its territories, and the Commonwealth of Puerto Rico. The NEA will support health care reform measures that move the United States closer to this goal. The NEA shall, therefore, do the following:

1. Expand education efforts directed to rank-and-file members on the problems and solutions to the health care crisis.

2. NEA shall encourage state affiliates to immediately educate and mobilize their members on behalf of NEA's single-payer health policy. This effort should include, but not be limited to, respective Congressional representatives and the Clinton Administration and coalition work with other single payer organizations.

3. Provide special assistance to states in attaining coverage through state and/or local action, in coalition building, and in developing health care data systems for use in planning and implementing Association health care crisis programs.

4. Continually assess, with the assistance of state affiliates, the impact of proposed national health insurance legislation on state and local governments, NEA members, domestic partners and dependents, and students, and make necessary recommendations for support, modification, and/or opposition to such proposed national health insurance legislation.

5. Continue for the 1993-94 fiscal year a state Association president/executive director/NEA Board of Directors committee that will make recommendations to the NEA president on NEA national health care strategies and program proposals.

6. Utilize monies allocated in the budget for health care in accordance with the terms of this New Business Item.

7. Make a special report and recommendations to the 1994 NEA Representative Assembly on health care program efforts and developments in health care proposals, especially those related to a national single-payer health care plan.

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